

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7558

## CERTIFICATE OF DEATH

07549

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>8400 Harris Avenue</i>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> d. STREET ADDRESS <i>8400 Harris Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <i>Mrs. Lillian Ackerman</i> First Middle Last 4. DATE OF DEATH <i>July 18th 19 61</i> Month Day Year			<b>5. SEX</b> <i>female</i> <b>6. COLOR OR RACE</b> <i>white</i> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>1-21-1893</i> <b>9. AGE (In years last birthday)</b> <i>68</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Maryland</i> <b>12. CITIZEN OF WHAT COUNTRY? <i>USA</i></b>			<b>13. FATHER'S NAME</b> <i>Charles Hinkel</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Zang</i>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <i>217226999</i> <b>17. INFORMANT</b> <i>Mrs. Jeanne White</i> Address <i>8400 Harris Avenue.</i>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>163X</i> IMMEDIATE CAUSE (e) <i>Carcinoma of the lung.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year <i>19</i> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>January 19 61</i> , to <i>7-18</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>7-18</i> , 19 <i>61</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.		
<b>22a. SIGNATURE</b> <i>J. Duer Moores</i> M.D. <b>22b. DATE SIGNED</b> <i>7-18-61</i> <b>22c. PHYSICIAN'S NAME</b> (Type) <i>J. Duer Moores</i> <b>22d. ADDRESS</b> <i>3105 Belair Rd.</i>			<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i> <b>23b. DATE THEREOF</b> <i>7-21-61</i> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Parkwood Cemetery</i> <b>23d. LOCATION</b> (City, town or county) (State) <i>Baltimore, Maryland</i>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> <b>25a. REC'D BY REGISTRAR</b> <i>Arthur S. Kline</i> <b>25b. REGISTRAR'S SIGNATURE</b>			<b>DATE</b> <i>JUL 21 '61</i>		

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MAYORAL STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07550

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 26 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>3404 W. Mulberry St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Long</u> Last <u>Aldridge</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/86</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traffic Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas A. Aldridge</u>				14. MOTHER'S MAIDEN NAME <u>Ida Zimmerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>170-03-1333</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiac Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>13/18 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Far Advanced Pulmonary Tuberculosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/18</u> 19 <u>60</u> to <u>7/14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> 19 <u>61</u> , and that death occurred at <u>6:55 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Newcomer</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. 29, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F.D. 4101 Edmondson Ave</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1252

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7560  
CERTIFICATE OF DEATH

07551

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8402 Beryl Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estella</u> Middle <u>M.</u> Last <u>Andrews</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Stephen Benson</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral metastases - disseminated</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18</u> , 19 <u>61</u> , to <u>July 18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> , 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Franklin D. Schwantz</u>		22b. DATE SIGNED <u>7-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Franklin D. Schwantz</u>		22d. ADDRESS <u>7122 Hartford Rd #14</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7-21-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 21 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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Received of the Treasurer of the  
County of ...  
the sum of ...  
for ...  
this 10th day of ...  
1901

FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**7561 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07552

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1107 Boyce Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> d. STREET ADDRESS <b>1107 Boyce Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Theodore Hahn Ascherfeld</b>				4. DATE OF DEATH <b>July 14, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Frederick A. Ascherfeld</b>		14. MOTHER'S MAIDEN NAME <b>Letitia Cousins</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Coronary Occlusion Sudden</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>7/15/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>7-17-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR <b>Wm. J. Jackson &amp; Sons</b>				ADDRESS <b>Balt 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 17 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

MEDICAL CERTIFICATION

88552

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
DEATH CERTIFICATE

FILE NO.  
1940

(M)

(I)

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1 **M**  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**7562**  
**CERTIFICATE OF DEATH**  
**07553**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>1mth18dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>19 Delrey Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Ellen</b> Last <b>Ayer</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Columbus McIntosh</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McVicker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 25, 1961</b> to <b>July 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 24, 1961</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>7-24-61</b>	
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>GRAFTON W. VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Cavanaugh F.H. - Catonsville, Md.</b>		25. REC'D BY REGISTRAR <b>JUL 27 61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

07550

07550

(M)

(1)

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*

*[Handwritten notes at the bottom of the page, including "Page 1" and "10/21/50".]*



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X  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7563 CERTIFICATE OF DEATH 07554

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>COCKEYSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PADONIA ROAD</b>		d. STREET ADDRESS <b>1 PADONIA ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>Mantha Bentha Bange</b>		4. DATE OF DEATH <b>July 26 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1895</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? KRUGER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>FAMILY RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 7 1961</b> to <b>July 26 1961</b> , that (I) (we) last saw the deceased alive on <b>July 25 1961</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Elyabeth B. Sherrill</b>		22b. DATE SIGNED <b>7/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill M.D.</b>		22d. ADDRESS <b>Cockeysville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SUNNYBROOK, BALTO CO., MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

0750

CERTIFICATE OF DEATH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Pikesville</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>112 Church Lane</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>112 Church Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah Frey Barnwell</b>				4. DATE OF DEATH <b>July 13 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1884 November 19, 1891</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John G. Frey</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Achuss</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Elizabeth B. Titus-738 Fontaine St.</b>				Address <b>Alexandria, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b>							
415X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Rheumatic C.-V. Disease</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>10 yrs (est)</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. CATLES</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>Woodlawn, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 15, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or country) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR <b>Wm. J. Dicknew &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>JUL 17 '61</b>			
ADDRESS <b>Balta. 17 Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7563

CERTIFICATE OF DEATH

07556

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>16 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				d. STREET ADDRESS <u>604 E. Gittings Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>L.</u> Last <u>Barr</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 61</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1878</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Lacey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah A. Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-07-5379</u>		17. INFORMANT <u>Admission Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>(b) (c) (scri)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>June 26, 19 61</u> to <u>July 11, 19 61</u> that (I) <u>yes</u> last saw the deceased alive on <u>July 10, 19 61</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert J. Mahon M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u>				22d. ADDRESS <u>602 E. Joppa Rd. Towson 4, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-14-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran Church Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pine Grove, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Zone 4</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION

03384

CERTIFICATE OF DEATH

1954

(M)

Blank form with faint horizontal lines and vertical columns, typical of a death certificate template. The form includes fields for personal information, cause of death, and official certification.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07557

FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rowley's Quarters #20</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Seneca Creek off 69 Clark's Pt. Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALVIN O. BASEMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1919</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Oliver Baseman</u>				14. MOTHER'S MAIDEN NAME <u>Ida Sharf</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO. <u>217-01-9536</u>		17. INFORMANT <u>Lena Idelwood 320 Linwood Ave. #14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING,</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>WAS Thrown from Boat while "Hoop" playing</u>							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>
20c. TIME OF INJURY Month, Day, Year Hour <u>4</u> p.m. <u>7-4-61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Seneca Cr. Middle River in Boat</u>		20f. (City or town) (County) (State) <u>Middle River in Baltimore</u>	
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M B Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>7/4/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>James E. Brudzinski</u>				ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

10-25-51

3266 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

(1)

Deceased

For the purpose of this report, the deceased was found by the coroner's jury to have died of natural causes.

Witness  
J. H. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7567

CERTIFICATE OF DEATH

07558

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>22 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (1)</b> d. STREET ADDRESS <b>830 George Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>CLINTON --- BLANKS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>July 20 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 16, 1905</b>
<b>9. AGE</b> (In years last birthday) yrs. <b>56</b>		<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Trucking</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>James E. Blanks</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lena Douglas</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-01-6417</b>	
<b>17. INFORMANT</b> <b>Clinical Records, VAH Baltimore 18, Maryland</b>		<b>Address</b> <b>Fort Howard Division</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTRIC HEMORRHAGE</b> DUE TO <b>RECURRENT ADENOCARCINOMA OF STOMACH</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>METASTATIC CARCINOMA, LYMPH NODES AND LIVER</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Arteriosclerotic Heart Disease - duration unknown (2) Arteriosclerotic Gangrene, 1st, 2nd, 3rd, and 4th Toes of Right Foot - duration unknown.</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <del>no</del> (this hospital) attended the deceased from <b>June 28, 1961</b> , to <b>July 20, 1961</b> that <del>no</del> (we) last saw the deceased alive on <b>July 20, 1961</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i> <b>THOMAS F. CRAHAN, M.D.</b>		<b>22b. DATE SIGNED</b> <b>7/20/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>7-24-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 27 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Caroline L. Thomas</i>			

01228

01228



TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

FROM THE COMMISSIONER, BUREAU OF REVENUE, WASHINGTON, D. C.

SUBJECT: [Illegible]

[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a formal communication or report.]

7568

## CERTIFICATE OF DEATH

Reg. Dist. No. 07559

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3517 Hillsmere Rd.</b>				d. STREET ADDRESS <b>3517 Hillsmere Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Margaret Blickenstaff</b>				4. DATE OF DEATH Month Day Year <b>July 3, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1869</b>	
9. AGE (In years lost birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Fountain Dale, PaK</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Flohr</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>			
INFORMANT Address <b>Mildred K. Taylor 3517 Hillsmere Rd.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio-Sclerosis</b> DUE TO (c) <b>Senile Psychosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>5 yrs.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 7</b> , 19 <b>55</b> , to <b>July 3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>July 2nd</b> , 19 <b>61</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <b>4108 Liberty Hts. Ave. Balto. 7-32</b>							
ACTUAL SIGNATURE <b>Earl L. Chambers</b> M.D. <b>4108 Liberty Hts. Balto. Md.</b>							
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b> <b>4108 Liberty Hts. Balto. Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/5/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Pennsylvania</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 5 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Charles S. Rouse</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF ARIZONA  
COUNTY OF COCHISE  
I, the undersigned, a Notary Public in and for the State of Arizona, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of Cochise, State of Arizona, and that the same is a true and correct copy of the original of the same as the same appears from the records of the County of Cochise, State of Arizona.

Notary Public in and for the State of Arizona



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**7569** **CERTIFICATE OF DEATH**

07560

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>22 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2164 Druid Park Drive</u> d. STREET ADDRESS <u>2164 Druid Park Drive</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Helen Frances Boggs</u>		<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>10</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2/6/33</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>dependent</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>	<b>9. AGE</b> (In years last birthday) <u>28</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Paul Boggs</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Myrtle Tilly</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> <u>Rosewood Records - Owings Mills, Md.</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Atelectasis, massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Aspiration pneumonitis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Spastic paraplegia, since birth</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1/2 hour</u> <u>2 hours</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/5</u> , 19 <u>39</u> , to <u>7/10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>61</u> , and that death occurred at <u>9:15 a.m.</u> the causes and on the date stated above.			
<b>22e. SIGNATURE</b> <u>Harry G. Butler</u>		<b>22b. DATE SIGNED</b> <u>7/10/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Harry G. Butler, M.D.</u>		<b>22d. ADDRESS</b> <u>Rosewood State Training School</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7/12/1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Mem. Gardens</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Bel Air</u> <u>Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Furt</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUL 12 '61</u>	
<b>ADDRESS</b> <u>Jarrettsville Md</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Furt</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7570

07561

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clippersco, Balto. Co. Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor - Lutherville Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>C.</u> Last <u>Belgiau</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Blatla</u>	
13. FATHER'S NAME <u>Samuel Robuison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Culhou</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>E. Kurzejeski (RNU)</u>		Address <u>54 Timonium Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myo cardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>moments</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest C. Brown Jr.</u> M.D.		22b. DATE SIGNED <u>July 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>		22d. ADDRESS <u>1101 N. Calvert Street, Baltimore 2, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-19-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1961</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7571

Items 8, 10, 11, 12 & 14 fill in 7/18/61

07562

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH e. COUNTY <b>BALTIMORE</b>		f. STATE <b>MD.</b>		b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>219 MORRIS AVE</b>		d. STREET ADDRESS <b>219 MORRIS AVE</b>			
3. NAME OF DECEASED (Type or print) <b>ALFRED RALPH BOLZ</b>		4. DATE OF DEATH <b>JULY 4 1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1939</b>	9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>ALFRED RAYMOND BOLZ</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND, HEAD</b> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>HEMOPHILIA</b>					INTERVAL BETWEEN ONSET AND DEATH
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/4/61</b>	
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>TIMONIA, MD. Bldg. 7/4/61</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>7/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	
22d. LOCATION (City, town, or country) <b>Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	
23. FUNERAL DIRECTOR <b>John Burns Sons. Towson, Md.</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7572  
CERTIFICATE OF DEATH  
07563

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths8dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belair, Maryland</b>		d. STREET ADDRESS <b>Route #2 - Clayton Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Flossie</b> Middle <b>Bostic</b> Last <b>Brannon</b>		4. DATE OF DEATH Month <b>July</b> , Day <b>29</b> , Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1908</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Estel Bostic</b>		14. MOTHER'S MAIDEN NAME <b>Mary Atkinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>179-20-9233</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>B r o n c h i a l P n e u m o n i a</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabeties</b> DUE TO <b>C e b e r a l V a s c u l a r A c c i d e n t</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1961</b> to <b>7-29-1961</b> , that (I) (we) last saw the deceased alive on <b>7-29-1961</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Ricardo Ibanez</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RICARDO IBANEZ</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>July 31, 1961</b>		23b. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>	
23c. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Maryland</b>		23d. DATE <b>AUG 2 '61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K McCornes</b>		25a. REC'D BY REGISTRAR <b>Arthur E. Kraus</b>	
25b. REGISTRAR'S SIGNATURE		25c. DATE	

07663

CENTRE CASE OF DEATH

1312

(M)

3-20-10

1-2-10-10

1-2-10-10

1-2-10-10

1-2-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7573  
07564  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		d. STREET ADDRESS <b>Box 338B, Woodland Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE H. BRIGGS</b>		First Middle Last		4. DATE OF DEATH <b>JULY 8 1961</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/26/12</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Briggs</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Miller</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Glin.Rec.VAH,Balto. Md. Fort Howard Division</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR LEFT TEMPORAL LOBE, ASTROCYTOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>HYPERSTATIC PNEUMONIA LOWER LOBES</b> (c) <b>12 HOURS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Estimated 6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 3, 1961</b> to <b>July 8, 1961</b> , that (2) (we) last saw the deceased alive on <b>July 8, 1961</b> , and that death occurred <b>2:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. J. Pijanowski</b>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>		<b>7/9/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>125 July 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Singleton's Funeral Home</b>		ADDRESS <b>200 Crain Highway, S.W. Glen Burnie, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

1000

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
BERTHA C. BROSEKER		July 22, 1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore County Baltimore - 7 3512 Keston Rd.		A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) X Baltimore 7 D. STREET ADDRESS (If rural, give location) 3512 Keston Rd.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	widowed	Sept. 11, 1880
9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
80		Housewife	
10a. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
USA		Evan T. Scott	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	
Sophia E. Reed		no	
16. SOCIAL SECURITY NO.		17. INFORMANT	
215-07-1319 D		Charles William Broseker	
18. CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 Coronary Thrombosis (acute) 1 day ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Arteriosclerotic Cardiovascular Disease 6 years (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19. DATE OF OPERATION		20. AUTOPSY?	
May 10		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from July 22, 1961, to July 22, 1961, and that in (my) (our) opinion death occurred on July 21, 1961, from the causes and on the date stated above.		22. I certify that (I) (this hospital) attended the deceased from May 10, 1961, to July 21, 1961, and that in (my) (our) opinion death occurred on July 21, 1961, from the causes and on the date stated above.	
23a. SIGNATURE		23b. ADDRESS	
Samuel B. Wolfe		1331 E. North Ave	
23c. DATE SIGNED		24. LOCATION	
7/23/61		Baltimore Md.	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
Burial		Jul. 25, 1961	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION	
Loudon Park Cemetery		Baltimore Md.	
25a. DATE REC'D BY HEALTH DEPT.		25b. NAME OF REGISTRAR	
JUL 24 1961		Henry Sander & Sons, Inc.	
25c. FUNERAL DIRECTOR		ADDRESS	
Baltimore Md.			





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7575

07566

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs. 7 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>8 W. Read St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Carrington Brown</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1870</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>French Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Richardson Brown</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Carrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lonia Zeller K.N. College Manor</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis with calcification</u> DUE TO <u>a cerebral vascular involvement,</u> (c) <u>75 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1956</u> to <u>July 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 31, 1961</u> , and that death occurred at <u>10:35 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas E. Van Metre Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS E. VAN METRE JR</u>		22d. ADDRESS <u>1014 ST PAUL ST Baltimore 2</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-3-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS &amp; Sons Co. 4905 YORK RD. BALTO. 12</u>		25a. REC'D BY REGISTRAR <u>AUG 2 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

1968

EXHIBIT A OF DEATH

1975

(M)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Faint", "Faint", "Faint" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7576

07567

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore -4</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1531 Joppa Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>111-W-29th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lucy Hand Browne</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1871</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Hand Browne</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Jennings</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. R.C. Hall (Niece)</b>		Address <b>1531 W. Joppa Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>arteriosclerotic heart disease</b> DUE TO <b>Carcinoma colon, metastatic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years?</b> <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 1961</b> to <b>July 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 6, 1961</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
22e. SIGNATURE <b>Newland Edward Day</b> M.D.		22b. DATE SIGNED <b>July 10, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEWLAND EDWARD DAY MD</b>		22d. ADDRESS <b>4-E-33rd St Balto 18th</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>July 10/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City, town or county) (State) <b>Pikesville, Balto. Co.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart &amp; Mowen Co. 108 W. North Balto.</b>		25a. REC'D BY REGISTRAR <b>7-10-61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

7530

07567

Baltimore

Baltimore

Baltimore

Baltimore

11-1-11

11-1-11

July 11, 1911

July 11, 1911

Wife

August 11, 1911

none

none

Baltimore, Md.

B.M.

William H. Brown

Harry C. Brown

no

no

Mr. R.C. Hill (Niece) 1001 N. W. 10th St.

Carroll County, Md.  
Baltimore, Md.  
Baltimore, Md.

Baltimore  
Baltimore  
Baltimore

(I)

July 11

January 11, 1911

Newport News

Newport News, Va. 4-32-11

July 11, 1911

July 11, 1911

July 11, 1911

Stewart & Brown Co. 108 W. North Baltimore 7-10-11

7577

CERTIFICATE OF DEATH

Reg. Dist. No. 07568

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 Willow Avenue</u>		d. STREET ADDRESS <u>200 Willow Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Clayton G. Burch</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7th</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Burch</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Swan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-1891</u>	
17. INFORMANT <u>Mrs. Hazel V. Burch</u>		Address <u>200 Willow Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> DUE TO <u>(probably primary)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>7/7</u> , 19 <u>61</u> , that I lost saw the deceased alive on <u>7/7/61</u> , 19 <u>61</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>6305 Inverness - 12</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>7/8/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/10/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #144</u>	
24a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1537

15383

1. PLACE OF DEATH		2. DATE OF DEATH	
HOME		JANUARY 1, 1911	
3. NAME OF DECEASED		4. SEX	
JOHN J. JONES		MALE	
5. AGE		6. OCCUPATION	
45		LABORER	
7. CAUSE OF DEATH		8. PLACE OF BURIAL	
HEART DISEASE		CATHOLIC CHURCH	
9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
[Signatures]		[Signature]	
13. SIGNATURE OF CLERGYMAN		14. SIGNATURE OF DECEASED	
[Signature]		[Signature]	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
[Signature]		[Signature]	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
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19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
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97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
[Signature]		[Signature]	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	
[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE											
7578											
CERTIFICATE OF DEATH											
07569											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY in 1b <b>4 HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> g. STREET ADDRESS <b>3019 West Belvedere Avenue</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOSEPH B. CALLAHAN</b>						4. DATE OF DEATH <b>July 31 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1895</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Interior Decorator</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard Callahan</b>						14. MOTHER'S MAIDEN NAME <b>Ellen Lynch</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW-1 212-16-5802</b>		17. INFORMANT <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>EMPHYSEMA, BILATERAL</b> XXXXX (c) <b>CHRONIC CALCIFIC PLEURITIS,</b> ARTERIOSCLEROSIS, GENERALIZED Duration Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19 5:20 PM</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9:20 PM</b> 20f. (City or town) (County) (State)											
21. I certify that (X) (this hospital) attended the deceased from <b>July 31 19 61</b> to <b>July 31 19 61</b> , that (X) (we) last saw the deceased alive on <b>July 31 19 61</b> , and that death occurred at <b>8:20 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.						22b. DATE SIGNED <b>8/1/61</b>					
22c. PHYSICIAN'S NAME <b>THOMAS F. CRAHAN, M.D.</b>						22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14,</b>						25a. REC'D BY REGISTRAR <b>AUG 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. King</b>			

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8/1/52

V.H. BALTIMORE 25, MD., TO HOWARD DIVISION

THOMAS T. GRAHAM, W.D.

8-4-52 Baltimore National Cemetery, Baltimore 20, Maryland

8-4-52 Baltimore National Cemetery, Baltimore 20, Maryland

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## 1

M

## 625275-79

07570

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>924 BELGIAN AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GEORGE W CHRISTIAN</b>			4. DATE OF DEATH <b>JULY 4 1961</b>		
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>MARCH 30, 1886</b>		
9. AGE (In years last birthday) <b>75</b> yrs.			10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>GEORGE CHRISTIAN</b>			14. MOTHER'S MAIDEN NAME <b>MARY MCARA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <b>216-03-1610</b>		
17. INFORMANT <b>CARTER CHRISTIAN (SON)</b>			Address <b>924 BELGIAN AVE.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> <b>Cerebral artery occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized arteriosclerotic changes</b> (b) <b>2 days</b> (c) <b>2 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1961</b> to <b>July 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1961</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>J. Nelson McKay</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>J. NELSON MCKAY</b>					
22d. ADDRESS <b>6014 EDMONDSON AVE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					
23b. DATE THEREOF <b>JULY 7, 1961</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>MCADOWRIDGE</b>					
23d. LOCATION (City, town or county) (State) <b>HOWARD CO. MD.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. MacNabb &amp; Co</b> ADDRESS <b>BALTO 28, MD</b>					
25a. REC'D BY REGISTRAR <b>JUL 10 '61</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

(M)

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Admission Ticket

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Source Information

Christian

March 30, 1980

Myanmar

Mr. of Myanmar

and his wife (Christian) (see)

The above

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7580

07571

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>9 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> (22) d. STREET ADDRESS <b>4105 Eder Road</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>LOUIS L. CITRO</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>5</b> Year <b>19 61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1921</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Palmarino Citro</b>		
14. MOTHER'S MAIDEN NAME <b>Josephine Del Juidice</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		
16. SOCIAL SECURITY NO. <b>212-16-6822</b>			17. INFORMANT <b>Clinical VAH, Baltimore 18, Maryland</b> <b>Records FORT HOWARD DIVISION</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CORONARY INSUFFICIENCY</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, GENERALIZED</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>July 5, 12:30 1961</b> to <b>July 5, 1961</b> , that (X) (we) last saw the deceased alive on <b>July 5, 1961</b> , and that death occurred at <b>AM 9:30</b> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.			22b. DATE SIGNED <b>7/5/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>			22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-7-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
<b>Baltimore 28, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda, 7922 Wise Ave., Dundalk 22, Md.</b>			25a. REC'D BY REGISTRAR <b>JUL 7 '61</b>		
25b. REGISTRAR'S SIGNATURE <i>Archie L. Thomas</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7581

Item 2 Film G292 7/31/61

07572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore Catonsville</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shady Nook Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>N. Y. Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore New York</b> d. STREET ADDRESS <b>Grgswold Apts., Garth Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>B</b> Last <b>lanche</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1886</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Wm. R. Rice</b>		14. MOTHER'S MAIDEN NAME <b>Blanche E. ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Name <b>Mrs. Janice M. Baker - Maple Ave. Balto.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350X S - fracture of age</b> DUE TO (b) <b>Parkinson Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1961</b> to <b>July 20, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 19, 1961</b> , and that death occurred at <b>1961</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas B. Abbott</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas B. Abbott</b>		22d. ADDRESS <b>4509 Liberty Street, Balto.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Jackson - Sons Balto 17 Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUL 24 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraser</b>

03833

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(M)

*Latent*

(1)

*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some words like "Latent" and "1337" are visible.]*

# 1 FOR STATE HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 7582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07573

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. LENGTH OF STAY IN 1b <b>2 Vol-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bethlehem Steel Co. Dispensary</b>				d. STREET ADDRESS <b>1904 E. Pratt St. 31</b>			
3. NAME OF DECEASED (Type or print) <b>George M. Collins</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-11-1905</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b>		IF UNDER 24 HRS. Hours <b>56</b> Min. <b>56</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Bath</b>			
11. BIRTHPLACE (State or foreign country) <b>Eastern Shore Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Collins</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-07-0838</b>			
17. INFORMANT <b>Louise Sophia Balcerowicz</b>				Address <b>1904 E Pratt St</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Jack E Collins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK E Collins</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-27-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Balto. 6 Md</b>	
23. FUNERAL DIRECTOR <b>Dyppel Bros. 1800 E. Lombard St.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>40 Days</b>		d. STREET ADDRESS <b>Llewellyn Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN F. COOPER</b>		4. DATE OF DEATH <b>July 29 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 19, 1896</b>	
9. AGE (In years last birthday) <b>64</b>		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>18</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathaniel Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Simpson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>201-10-2574</b>	
17. INFORMANT <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>		Address <b>VAH Baltimore Md - Ft Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF RIGHT KIDNEY, METASTATIC TO LUNG</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Encephalomalacia; 2. Arteriosclerotic Heart Disease.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>June 19 1961</b> to <b>July 29 1961</b> that <b>he</b> (we) last saw the deceased alive on <b>July 29 1961</b> and that death occurred at <b>3:25AM</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>7-29-61</b>	
22a. SIGNATURE <b>John A. Smith</b>		22c. PHYSICIAN'S NAME (Type) <b>VAH Baltimore 18 Md - Ft Howard Division</b>	
22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug-1-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>		25. REC'D BY REGISTRAR <b>AUG 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. ADDRESS <b>1000 Brantley Avenue Baltimore 17 Md</b>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07575

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Milford Mill Swimming Pool</b>		d. STREET ADDRESS <b>540 Woodside Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>SHARON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1953</b>
9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Cooperman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Flaxman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Cooperman-- Same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into swimming pool.</b>	
20c. TIME OF INJURY Hour <b>4:00</b> p.m. Month, Day, Year <b>7/24 61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Swimming Pool</b>	20f. (City or town) (County) (State) <b>Pikesville Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/25/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ohel Yakov Cong.</b>
23. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS INC</b>		24. REC'D BY REGISTRAR <b>JUL 27 '61</b>	
ADDRESS <b>6010 Reist Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	
22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>		DATE <b>JUL 27 '61</b>	

(M)

1934

Baltimore

Pineville

Millard Hill Swimming Pool

SHADE

DEEP END

July

250 Riverside Avenue

Female White

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General

Swimming

Admission

Swimming

Left into swimming pool.

1:00

1/2 of

\* Swimming Pool

Pineville

Baltimore Md.

X

X

Charles S. Kelly, M.D.

1934

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7585 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07576

FOR STATE HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Md.</u>				c. LENGTH OF STAY IN b. <u>7 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt. Wilson State Hosp.</u>				d. STREET ADDRESS <u>17300 Golden Ring Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>CHAS.</u> Middle <u>A.</u> Last <u>COUGLE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-19</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warrior</u>		11. BIRTHPLACE (State or foreign country) <u>Texas, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas. A. Cougle</u>				14. MOTHER'S MAIDEN NAME <u>Eliz. Poe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes. W.W.II</u>				16. SOCIAL SECURITY NO. <u>3-12-12-4460</u>			
17. INFORMANT <u>Mt. Wilson Hosp. Records - Mt. Wilson</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Tho.</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Hour a.m. <u>None</u> p.m. <u>None</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <u>D.D. Caples</u> EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>				DATE SIGNED <u>July 1 '61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or country) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR <u>John B. Connelly</u>				24. RECORD BY REGISTRAR <u>418 Eastern Blvd.</u>			
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>JUL 5 '61</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07577

7586

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PIKESVILLE</u>		d. STREET ADDRESS <u>125 W. Slade Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THORNTON WEBSTER COX</u>		4. DATE OF DEATH Month Day Year <u>7 - 11 - 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/74</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM T. COX</u>		14. MOTHER'S MAIDEN NAME <u>FRANCIS ENSOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-5368</u>	
17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X</u> <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cox Pulmonale</u> (c) <u>Severe arteriosclerosis - dissecting</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-5-</u> 19 <u>61</u> , to <u>7-11-</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-11-</u> 19 <u>61</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. Newcomer</u>		22b. DATE SIGNED <u>7/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-12-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Curtis S. Frank</u>			

01737

3586

(M)

WILLIAM T. C. FRANCIS JUNIOR

212-21-2385

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100 N. 5TH ST. NEW YORK 17, N.Y.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the funeral director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7587

Item 8 File 0292 7/31/61 ink

Reg. Dist. No. 07578

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1442 Barrett Rd		d. STREET ADDRESS 1442 Barrett Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Albert Croftcheck		4. DATE OF DEATH Month Day Year July 22 1961 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1918 Oct. 29 1918
9. AGE (In years last birthday) 42 1/4 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Polisher		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork Seal	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Michael Croftcheck		14. MOTHER'S MAIDEN NAME Anna Subala	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 159*14* 2158	
17. INFORMANT Address Steven Dudash. 1442 Barrett Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 22, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/26/61	
22c. NAME OF CEMETERY OR CREMATORY LAKELAFETTE MEM.		22d. LOCATION (City, town, or county) (State) UNIONTOWN PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Black Marucci Republic, Pa.		24a. REC'D BY REGISTRAR DATE JUL 24 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thrall			

Letter sent to Fred Marucci regarding 7/26/61 change of age as requested by Mr. W.H. I

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07579

FOR STATE HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY. <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN b. <b>3yr2mth26dys</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>115 Oaklee Village</b> <b>115 Oakley Village</b>			
3. NAME OF DECEASED (Type or print) <b>Katherine E. Culleton</b>				4. DATE OF DEATH <b>July 8 1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1890</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>office nurse</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis Lynch</b>				14. MOTHER'S MAIDEN NAME <b>Rose Roller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-05-4399A</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>903.7</b> DUE TO <b>acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>dehydration, Hypostatic Pneumonia</b> (c) <b>(decubitus) / Senility, Accident</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smith-Peterson Hip pinning performed on 4-12-61</b>						19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell on bathroom floor on 3-22-61 sustaining a comminuted intertrochanteric fracture of the right femur</b>					
20c. TIME OF INJURY <b>12:15 p.m.</b> <b>3-22 1961</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) <b>Catonsville 28, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>George M. Kieffer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>1016 Leach on</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue</b>		24a. REC'D BY REGISTRAR <b>JUL 11 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

MEDICAL CERTIFICATION

THE STATE  
OF NEW YORK

(M)

(1)

7322

WILLIAM STRAIN & COMPANY OF NEW YORK

7322

HOWARD H. HOBBS, 1101 BROADWAY, NEW YORK 10  
JULY 11, 1911  
NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7589

07580

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1112 DUMBARTON RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>1112 DUMBARTON RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>E. GUILBERT CUSTY</u> First Middle Last		4. DATE OF DEATH <u>JULY 22 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 2, 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEA + COFFEE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>J. EDWARD CUSTY</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET PARKS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give year or dates of service) <u>W.W.I</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. E. Guilbert Custy - 1112 Dumbarton Rd.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1961</u> to <u>July 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1961</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>A. Allan Spier</u> 22c. PHYSICIAN'S NAME (Type) <u>A. ALLAN SPIER</u>		22b. DATE SIGNED <u>7/25/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1501 Pinkbridge Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balti. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Company</u> ADDRESS <u>628 - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 28 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

2255

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07581

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex #21</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Essex #21</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1621 "1" Gail Road</u>		d. STREET ADDRESS <u>1621 "1" Gail Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Raymond</u> Last <u>Dabkowski</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1903</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ignatius Dabkowski</u>		14. MOTHER'S MAIDEN NAME <u>Frances Glinka</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-14-7053</u>	
17. INFORMANT <u>Frances Burkowski</u>		Address <u>507 S. Collington Ave #31</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Brudzinski</u>		24a. REC'D BY REGISTRAR <u>DATE: JUL 11 '61</u>	
ADDRESS <u>1407 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles F. K...</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No. 07582

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12 (Stoneleigh)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7118 Wardman Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Morton</b> Middle <b>Ward</b> Last <b>Demo</b>				4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1894</b>		9. AGE (In years last birthday) yrs. <b>67</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Electric</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Melvin Demo</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Hedding</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>074-01-1536</b>		INFORMANT Address <b>Dorothy Vaughn, 7118 Wardman Road, Zone 12</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Coronary Occlusion</b> DUE TO <b>Arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of cervical lymph glands</b> DUE TO (c) <b>5 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>One day</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>13 May</b> , 19 <b>61</b> , to <b>27 July</b> , 19 <b>61</b> , that I lost saw the deceased alive on <b>27 July</b> , 19 <b>61</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. Reier</b>				ADDRESS (Street, city or town, state) <b>6701 York Rd Balto 12 Md</b> DATE SIGNED <b>27 July 61</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Reier, M.D.</b>				<b>6701 York Road, Baltimore 12, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-29-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc.,</b> ADDRESS <b>1050 York Road, ZONE 4</b>				24a. REC'D BY REGISTRAR <b>JUL 31 61</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Charles S. [illegible]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07582

CERTIFICATE OF DEATH

7591

(M)

Full name of deceased  
Date of birth  
Place of birth  
Sex  
Race  
Marital status  
Occupation  
Cause of death  
Date of death  
Place of death  
Signature of physician  
Signature of registrar

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

## CERTIFICATE OF DEATH

Reg. Dist. No. 07583

7592

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>28</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 Smithwood Ave</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>110 Smithwood Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMILY TRENE DTEHLMAN</b> First Middle Last				4. DATE OF DEATH <b>July 30, 1961</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11, 1877</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>At Home</b>							
13. FATHER'S NAME <b>John Bretherton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John S. Gearhart, 110 Smithwood Ave, Catonsville</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>7/30/61</b>	
21. I certify that I attended the deceased from <b>7/25/61</b> to <b>7/30/61</b> , that I last saw the deceased alive on <b>7/25/61</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1303 Frederick Rd, Catonsville 28md</b> DATE SIGNED <b>7/31/61</b>							
ACTUAL SIGNATURE <b>W.E. McGrath M.D.</b>				DATE SIGNED <b>7/31/61</b>			
PHYSICIAN'S NAME (Type) <b>W.E. McGrath M.D.</b>				DATE SIGNED <b>7/31/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-2-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5882

1. NAME OF DECEASED J. I. I.		2. SEX M	
3. AGE 1		4. DATE OF BIRTH 1-1-1911	
5. PLACE OF BIRTH Texas		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION None		10. RELIGION None	
11. DATE OF DEATH 1-1-1911		12. TIME OF DEATH 11:00 AM	
13. PLACE OF DEATH Home		14. CAUSE OF DEATH Diphtheria	
15. DISEASE OR INJURY Diphtheria		16. PRESENTING COMPLAINT Sore throat	
17. HISTORY OF PRESENT ILLNESS Onset 12/20/10		18. PREVIOUS ILLNESS None	
19. TREATMENT None		20. PHYSICIAN'S SIGNATURE J. I. I.	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF WITNESSES J. I. I.	
23. SIGNATURE OF REGISTRAR J. I. I.		24. SIGNATURE OF CLERK J. I. I.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7593

## CERTIFICATE OF DEATH

07584

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>28</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hood Convalescent Home 5315 Edmondson Avenue</b>		d. STREET ADDRESS <b>401 Shadynook Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Lewis</b> Last <b>Dinges</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dinges</b>		14. MOTHER'S MAIDEN NAME <b>Anna Maienrinz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss June Aspril, 3903 Kimble Road, Baltimore</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA STOMACH</b> DUE TO <b>ARTERIO SCLEROTIC CHRONIC VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EDEMA</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>11/1</b> <b>1961</b> to <b>7/9</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>7/9</b> <b>1961</b> , and that death occurred at <b>5800 Edmondson Avenue</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John H. Shaw</b>		22b. DATE SIGNED <b>7/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Shaw, M.D.</b>		22d. ADDRESS <b>5800 Edmondson Avenue, Zone 28</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUL 14 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

ERES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7594

07585

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN b. <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston, Maryland</b> d. STREET ADDRESS <b>Route #2 - Box 448</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry Jourdan Dixon</b> First Middle Last		4. DATE OF DEATH <b>July 4, 1961</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1895</b> 9. AGE (In years last birthday) <b>65</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tod crib attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glen L. Martin</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin L. Dixon</b>		14. MOTHER'S MAIDEN NAME <b>Emma Susan Cheneworth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-8829</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> <b>4-22-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Atherosclerotic cardiovascular disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1961</b> to <b>7/4</b> , 1961, that (I) (we) last saw the deceased alive on <b>7/4</b> , 1961, and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/6/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Bel Air Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Furtz</b>		25. REC'D BY REGISTRAR <b>JUL 7 '61</b>	
ADDRESS <b>Jarrettsville Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

07588

7596

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7595

CERTIFICATE OF DEATH

07586

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>35 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(VAH) Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3001-9</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (16)</b> d. STREET ADDRESS <b>3000 Mosher Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>E.</b> Last <b>DOWELL</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1893</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patrolman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>		11. BIRTHPLACE (County & State, or foreign country) <b>McHenry, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Stewart Dowell</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Crandall</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>215-28-8814</b>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE FAILURE</b> DUE TO <b>420-0</b> Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ADENOCARCINOMA, PANCREAS</b> (e), stating the underlying cause last. <b>DUODENAL ULCER - Duration Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 26, 1961</b> to <b>July 31, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 31, 1961</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/31/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Witke</b>				25a. REC'D BY REGISTRAR <b>AUG 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7596

07587

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>267</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b> d. STREET ADDRESS <b>Woodland Beach, Rt. 3, Box 593</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>JAMES V. DURLOO</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>October 27, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Sanderville, Georgia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles A. Durloo</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Wood</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>											
16. SOCIAL SECURITY NO. <b>219-12-2919</b>				17. INFORMANT Address <b>Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>METASTATIC CARCINOMA, CERVICAL LYMPH NODES &amp; LUNGS</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>XXXXX</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>												INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Benign Prostatic Hypertrophy</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from <b>October 12, 1960</b> to <b>July 6, 1961</b> , that (X) (we) last saw the deceased alive on <b>July 6, 1961</b> , and that death occurred at <b>p. 5:55</b> M, from the causes and on the date stated above.																			
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>7/7/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>								22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>7-10-61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, MD.</b>								ADDRESS				25a. REC'D BY REGISTRAR <b>JUL 11 '61</b>				25b. REGISTRAR'S SIGNATURE <i>Charles L. Thoms</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

SHIPPED TO: W. W. Chambers, Wash. D.C. 517 11th St. S.E.



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Belmont

Post Office

Box

Postmaster

Veterans Administration Hospital

Local Post Office, No. 1, Box 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>9 Overbrook Road</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9 Overbrook Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Catonsville</b> d. STREET ADDRESS <b>9 Overbrook</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katherine A. Eichner</b>		4. DATE OF DEATH <b>July 6, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug: 1-1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Frankla</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bauer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Minnie C. Poole-9 Overbrook Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>ARTERIO SCLEROTIC CHRONIC - VASOMOTONIC</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> to <b>7/6</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/6</b> , 19 <b>61</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Shaw M.D.</b>		22b. DATE SIGNED <b>7/7/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John W. Shaw M.D.</b>		22d. ADDRESS <b>5500 Edmonson Avenue, 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 10/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. Whippert</b>		25a. REC'D BY REGISTRAR <b>JUL 11 '61</b>	
ADDRESS <b>1300 Eutaw Pl.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7598

07589

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>22yr4mth10dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2003 E. Monumet St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Esposita</b> Last <b>—</b>		4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1895</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Anthony Esposita</b>		14. MOTHER'S MAIDEN NAME <b>Mary Laura</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Status convulsivus</b> DUE TO (c) <b>Idiopathic epilepsy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>5 minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 16, 1961</b> , to <b>July 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 26, 1961</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Jose A. Arizaga, M.D.</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Jose Arizaga, M. D.</b>		22b. DATE SIGNED <b>7-26-61</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>		22e. REC'D BY REGISTRAR <b>Jul 27 '61</b>	
22f. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>		22g. DATE <b>Jul 27 '61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION (City, town or county) (State) <b>Belair Road Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Farace Inc. 712-14 E. North Ave.</b>		25. REC'D BY REGISTRAR <b>Jul 27 '61</b>	
25a. REC'D BY REGISTRAR <b>Jul 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	

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 DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 07590

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>W. Va.</u> <del>MD</del> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpler</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shadybrook Nursing Home</u>		d. STREET ADDRESS <u>85X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>R.</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>United Pac. Coal Co. W. Va.</u>	
10a. FATHER'S NAME <u>Willis Evans</u>		10b. MOTHER'S MAIDEN NAME <u>Elizabeth L. Lloyd</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		12. SOCIAL SECURITY NO. <u>232-125411</u>	
13. INFORMANT <u>Jack Evans, 3510 Melody Lane Balto.</u>		14. ADDRESS <u>7. Md.</u>	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain malignancy (type unknown)</u> DUE TO (c) <u>6 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1961</u> to <u>July 31, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 31, 1961</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Edgar McKay</u>		22b. DATE SIGNED <u>8-1-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>601 &amp; Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Bluefield, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. W. 4101 Edmondson</u>		25a. REC'D BY REGISTRAR <u>AUG 2 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "W. W. W." and "1912" are faintly visible.]*

Reg. Dist. No. 07591

7600

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>419 LORRAINE AVE.</u>		d. STREET ADDRESS <u>1419 LORRAINE AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT M FITZ SR.</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 19-1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLEN L MARTINS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL L FITZ</u>		14. MOTHER'S MAIDEN NAME <u>EMMA SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-09-5216</u>	
17. INFORMANT <u>GEORGIA FITZ (WIFE)</u>		Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung with</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Metastases to bone - Rib + both</u> DUE TO (c) <u>Hips</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/9/61</u> , 19 <u>  </u> , to <u>3/19/61</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>7/18/61</u> , 19 <u>  </u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u> DATE SIGNED <u>7/21/61</u> ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D. <u>Bret 21, M.D.</u> PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, M. D.</u>			
22a. BURIAL CREMATION, (REMOVAL) (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>7-22-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HARBORBAUGH S</u>		22d. LOCATION (City, town, or county) (State) <u>PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u>		ADDRESS <u>418 Eastern Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

VS A15 (4)  
15M 9/5B

07301

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7601  
CERTIFICATE OF DEATH

07592

1. NAME OF DECEASED (Type or Print) <b>Rose M. Fogler</b>		2. DATE OF DEATH <b>July 19, 1961</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore County</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore - 6</b> <b>9409 Danavista Rd.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> d. STREET ADDRESS (If rural, give location) <b>9409 Danavista Rd.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 31, 1886</b>
9. AGE (in years last birthday) <b>75</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator C.C.&amp;S. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-24-1845</b>	
17. INFORMANT <b>Harry Fogler</b>		ADDRESS <b>414 Register Ave.</b>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.0</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>Arteriosclerotic Heart Disease</b> DUE TO (C) <b>Instantaneous</b> <b>over 2 yk.</b>	
19. DATE OF OPERATION <b>March 22, 1960</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1961</b> and that in (my) (our) opinion death occurred at <b>7:30 P.m.</b> from the causes and on the date stated above.		22. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1961</b> and that in (my) (our) opinion death occurred at <b>7:30 P.m.</b> from the causes and on the date stated above.	
23a. SIGNATURE <b>Stephen Toms, M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <b>4510 Bowleys Lane</b>	
23c. DATE SIGNED <b>7/20/61</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/22/61</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		24d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25a. DATE REC'D BY HEALTH DEPT. <b>JUL 24 1961</b>		25b. NAME OF REGISTRAR <b>Paul E. Chenoweth Jr.</b>	
25c. FUNERAL DIRECTOR <b>Paul E. Chenoweth Jr.</b>		ADDRESS <b>3617 Chestnut</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7602

CERTIFICATE OF DEATH

Reg. Dist. No. 07593

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6114 Rich Avenue</b>				d. STREET ADDRESS <b>6114 Rich Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Jane</b> Last <b>Foreman</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 10, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Henry Nelson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>212-16-8841</b>		17. INFORMANT <b>Milton Foreman</b> Address <b>6114 Rich Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma (Intestinal)</b> 5 Mos. 23 Days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>153.9</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 23rd, 1961</b> , to <b>July 29th, 1961</b> , that I last saw the deceased alive on <b>July 29th, 1961</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Winters Lane</b> DATE SIGNED <b>7/29/61</b>							
ACTUAL SIGNATURE <b>C.F. Maloney - M.D.</b>				PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Aug. 2, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Catonsville, Maryland</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b> ADDRESS <b>1808 N. Monroe St.</b>			
24a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7603

## CERTIFICATE OF DEATH

07594

Item 9 Film G290 7/19/61 iwk

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN TB <b>6 weeks</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>105 Rosewood Avenue</b>			d. STREET ADDRESS <b>76 Shipway</b>		
3. NAME OF DECEASED (Type or print) <b>FRANK MacMILLAN FRASER</b>			4. DATE OF DEATH Month Day Year <b>July 13th, 1961</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 15, 1887</b>		9. AGE (In years last birthday) <b>73 74</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>7 14</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alexander M. Fraser</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Mair</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-9244</b>	
17. INFORMANT <b>A.S. Fraser</b>		Address <b>3013 Dunran Road Dundalk 22, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Abdominal Carcinomatosis.</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Adeno-carcinoma of the Stomach.</b> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>61</b> , to <b>6-13</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-11</b> , 19 <b>61</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>JM Sanchez - Leon M.D.</b>		M.D. <b>JM Sanchez - Leon M.D.</b>		22b. DATE SIGNED <b>7/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JM Sanchez - Leon M.D.</b>		22d. ADDRESS <b>1114 St Paul St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore Co., Maryland</b>		24 FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>		ADDRESS <b>Dundalk 22, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

07584

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Robert Baker

Alexander H. Baker

Robert Baker

515-07-9211 A. H. Baker  
2023 Baker Road  
Lincoln, NE, Nebraska

Charles Alexander Baker  
Alexander H. Baker

X

Lincoln Co., Nebraska

One East Cemetery

W/1001

Unit 1

Walter Brooks Realty, Inc., Lincoln 25, Ne.  
W/1001 - Unit 1

7604

## CERTIFICATE OF DEATH

Reg. Dist. No. 07595

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. LENGTH OF STAY IN 1b <u>40yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dairy Rd.</u>				d. STREET ADDRESS <u>1 Dairy Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Alfred M. Freeland</u>				4. DATE OF DEATH <u>July 25, 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Luella Freeland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>716-12-3333</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> (c) <u>10 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> to <u>July 25, 1961</u> that I last saw the deceased alive on <u>July 24, 1961</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur Bortner</u>				DATE SIGNED <u>White Hall 2nd</u>			
PHYSICIAN'S NAME (Type) <u>Daniel Rostenstein, New Freedom, Pa.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Daniel Rostenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>July 31 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 07596

7605

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>				c. LENGTH OF STAY IN 1b <b>X DUNDALK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7032 DUNBAR ROAD</b>				d. STREET ADDRESS <b>7032 DUNBAR ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>OLWEN</b> First <b>GALLAGHER</b> Middle Last				4. DATE OF DEATH <b>JULY 18</b> 19 <b>61</b> Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 9-1907</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>PHILIP LEWIS</b>				14. MOTHER'S MAIDEN NAME <b>MARY SAMSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>GEORGE J GALLAGHER-7032 DUNBAR RD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYELO SARCOMA</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>DECEMBER</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>DECEMBER 60 to 18 JULY 1961</b> that I last saw the deceased alive on <b>18 JULY 1961</b> , and that death occurred at <b>7032 DUNBAR RD</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. BAERMANN</b> M.D.				DATE SIGNED <b>DR. W. E. BAERMANN</b>			
PHYSICIAN'S NAME (Type) <b>3401 Dundalk Avenue</b>				<b>Dundalk 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/22/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME-DUNDALK MD</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2035

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**Items 13 & 14 Film G292 8/15/61 iwk**  
**7605 CERTIFICATE OF DEATH**

Reg. Dist. No. **07597**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>X DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6903 RIDGEWAY RD.</u>				d. STREET ADDRESS <u>16903 RIDGEWAY RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FREDERICKA H. GEPHARDT</u>				<b>4. DATE OF DEATH</b> Month <u>JULY</u> Day <u>27</u> Year <u>1961</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>APRIL 5, 1889</u>	
<b>9. AGE</b> (In years lost birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Christain Seibert</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Ewig</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>WM. GEPHARDT 2114 LINCOLN RD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic heart disease</u> DUE TO (c) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ o. m. _____ p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>7-21</u> , 19 <u>61</u> , to <u>7-27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>61</u> , and that death occurred at <u>11:38</u> M, from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Leonard M. Zullo</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>7538 HOLABIRD AV.</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>LEONARD M. ZULLO</u>				<b>DATE SIGNED</b> <u>7-28-61</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>7/31/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK LAWN</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>COLGATE MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ULLICH FUNERAL HOME - DUNDALK MD.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>AUG 2 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of New York  
County of Albany  
I, the undersigned, a Justice of the Peace for the County of Albany, do hereby certify that on the 10th day of January, 1908, at the City of Albany, New York, died William J. Brown, of the County of Albany, New York, who was born on the 10th day of January, 1850, at the City of Albany, New York, and was a resident of the City of Albany, New York, at the time of his death. He was a member of the Grand Army of the Republic, and was a native-born American citizen. He was a man of good character and high standing in the community. He was a member of the Grand Army of the Republic, and was a native-born American citizen. He was a man of good character and high standing in the community. He was a member of the Grand Army of the Republic, and was a native-born American citizen. He was a man of good character and high standing in the community.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1 **MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7607

07593

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>331 Dumbarton Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>331 Dumbarton Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>George B. Gernhart</u> Middle Last <b>4. DATE OF DEATH</b> <u>July 21, 1961</u> Month Day Year		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 16, 1886</u> <b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired- Beth. Steel Co. (Steel Charger)</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Maryland</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U. S. A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Christian Gernhart</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Myra Bromwell</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>Mrs. Elenora Gernhart- 331 Dumbarton Road</u> <b>17. INFORMANT</b> <u>Mrs. Elenora Gernhart- 331 Dumbarton Road</u> Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerotic Cardio-Renal</u> Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Vascular Disease</u> (c) <u>10 yrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 19, 1961</u> <b>to</b> <u>July 21, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 19, 1961</u> <b>and that death occurred at</b> <u>3:45 PM</u> <b>from the cause and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Charles F. O'Donnell</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles F. O'Donnell M.D.</u>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>7/21/61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Entombment</u> <b>23b. DATE THEREOF</b> <u>7-24-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine Mausoleum</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Sicken+Sox</u> <u>Balto. 17, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>JUL 24 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

02559

1007



8



UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

Chief of Bureau, Federal Bureau of Investigation



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7608  
CERTIFICATE OF DEATH

07599

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY in lb <b>23m. 6days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE Hosp</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> f. COUNTY <b>BAIT.</b> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Reisterstown Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IDA</b> First Middle Last <b>VIRGINIA 611</b>		4. DATE OF DEATH Month Day Year <b>7 3 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>84 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown Jeremiah Baublitz</b>		14. MOTHER'S MAIDEN NAME <b>unknown Jane FRANK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>HOSPITAL'S RECORDS.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensatory heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 26, 1961</b> to <b>July 3, 1961</b> that (I) (we) last saw the deceased alive on <b>6/2, 1961</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b> M.D.		22b. DATE SIGNED <b>7-3-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 5, 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Falls Road Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		25. REC'D BY REGISTRAR <b>JUL 5 '61</b>	
ADDRESS <b>Reisterstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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07393

DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.  
1944

MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7609 CERTIFICATE OF DEATH

07600

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">MARYLAND</span> <div style="text-align: center; font-size: 1.2em;">Baltimore</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="float: right;">b. COUNTY</span> <div style="text-align: center; font-size: 1.2em;">Maryland Baltimore</div>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Woodlawn</div>			c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">Life</div>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div style="text-align: center; font-size: 1.2em;">1908 Hillcrest Road</div>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Woodlawn, Maryland</div>			
d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">1908 Hillcrest Road</div>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="text-align: center; font-size: 1.2em;">Stephen Jay Glenn</div>			<b>4. DATE OF DEATH</b> Month <span style="float: right;">Day</span> <span style="float: right;">Year</span> <div style="text-align: center; font-size: 1.2em;">July 21 1961</div>				
5. SEX <div style="text-align: center; font-size: 1.2em;">Male</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">White</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">June 6, 1956</div>		9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">5 yrs.</div>		IF UNDER 1 YEAR Months <span style="float: right;">Days</span> <span style="float: right;">Hours</span> <span style="float: right;">Min.</span>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">None</div>			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">Baltimore, Maryland</div>		
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U.S.A.</div>							
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">William J. Glenn</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Alice Ferguson</div>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address <div style="text-align: center; font-size: 1.2em;">William J. Glenn- 1908 Hillcrest Rd.</div>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span> <div style="text-align: center; font-size: 1.5em;">5873 CARDIAC FAILURE</div> <div style="text-align: center; font-size: 1.2em;">DUE TO</div> <div style="text-align: center; font-size: 1.2em;">1-2 yr.</div> <div style="text-align: center; font-size: 1.2em;">(b) CHRONIC PULMONARY DISEASE</div> <div style="text-align: center; font-size: 1.2em;">DUE TO</div> <div style="text-align: center; font-size: 1.2em;">4 1/2 yr.</div> <div style="text-align: center; font-size: 1.2em;">(c) CYSTIC FIBROSIS OF PANCREAS</div> <div style="text-align: center; font-size: 1.2em;">DUE TO</div> <div style="text-align: center; font-size: 1.2em;">5 yr.</div>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <span style="float: right;">Month</span> <span style="float: right;">Day</span> <span style="float: right;">Year</span> <div style="text-align: center; font-size: 1.2em;">19</div>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		
20f. (City or town) 			(County) 		(State) 		
21. I certify that I attended the deceased from <span style="float: right;">Dec 1959</span> to <span style="float: right;">July 21, 1961</span> , that I last saw the deceased alive on <span style="float: right;">July 19, 1961</span> , and that death occurred at <span style="float: right;">6:00 A.M.</span> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <div style="text-align: center; font-size: 1.2em;">Albert J. Weiss</div>			ADDRESS (Street, city or town, state) <div style="text-align: center; font-size: 1.2em;">4115 W. ROGERS Ave., Balto. 15</div>				
PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">Albert J. Weiss</div>			DATE SIGNED <div style="text-align: center; font-size: 1.2em;">7/22/61</div>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		22b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">7/24/61</div>		22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">Granite Presbyterian Cemetery</div>			
22d. LOCATION (City, town, or county) <div style="text-align: center; font-size: 1.2em;">Granite, Maryland</div>							
23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Ellsworth Armacost</div>			ADDRESS <div style="text-align: center; font-size: 1.2em;">4600 Liberty Heights Ave.</div>		24a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">JUL 24 '61</div>		
24b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Arthur S. Thomas</div>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.  
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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7610 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07601

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN 1b <b>19 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11 MIDWAY AVE</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DUNDALK (22)</b> d. STREET ADDRESS <b>11 MIDWAY AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>BLMER E. GOCHNOUR</b>			4. DATE OF DEATH Month <b>7</b> Day <b>22</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 4, 1900</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPER.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFGR</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>					
13. FATHER'S NAME <b>W. M. M. GOCHNOUR</b>			14. MOTHER'S MAIDEN NAME <b>MARY L. RESSLER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>193-05-5361</b>		
17. INFORMANT <b>EDNA HALE GOCHNOUR</b>			Address <b>AS #2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>420.1</b> DUE TO (c) <b>420.1</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>30 MINUTE</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>			22b. DATE THEREOF <b>7/25/61</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE MAUSOLEUM</b>			22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		
23. FUNERAL DIRECTOR <b>W. E. BAERMANN</b>			24a. REC'D BY REGISTRAR <b>26 '61</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7611

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07602

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>56 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5102 Craig Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>MAJOR F. E. GOFF</b>		4. DATE OF DEATH Month Day Year <b>JULY 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 16, 1896</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Duplin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Goff</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Goff Reeves</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>CLIN RECORD, FT HOWARD/VAH, BALTIMORE, MD.</b>	
17. INFORMANT <b>DIVISION</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>CARCINOMA OF TONGUE WITH METASTASIS</b> (c) <b>PULMONARY EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXX</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 24</b> ....., 19 <b>61</b> to <b>July</b> .....19 <b>61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 19</b> .....19 <b>61</b> , and that death occurred at <b>4:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph J. Cillo M.D.</b>		22b. DATE SIGNED <b>7/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. CILLO, M.D.</b>		22d. ADDRESS <b>BALTIMORE VAH, FT HOWARD DIVISION, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-24-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Seitz Funeral Home, 5209 York Rd. Balto 12, Md.</b>		25. REC'D BY REGISTRAR <b>JUL 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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Barbours

Fort Howard

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Veterans Administration Hospital

Barbours

Barbours

State of Maryland

Barbours

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Barbours

Barbours

December 16, 1946

White

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U.S. GOV. INTERNAL SEC. DIV. WASHINGTON, D.C.

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John T. Bell

John T. Bell

John T. Bell

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7612

## CERTIFICATE OF DEATH

07603

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 15 <u>2yr6mth21lds</u>		d. STREET ADDRESS <u>2905 Oakley Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph</u> Middle <u>Gordon</u> Last <u>Gordon</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>25</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Tazevnich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>217-01-0073</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Cerebral vascular accident</u> (c) <u>Arteriosclerotic thrombosis of the right internal carotid artery</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that <u>  </u> (this hospital) attended the deceased from <u>Jan. 3, 1959</u> to <u>July 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1961</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Aristides Simopoulos</u> M.D.		22b. DATE SIGNED <u>7-25-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Progressive Soc.</u>		23d. LOCATION (City, town or county) (State) <u>Randallstown Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		25c. REGISTRAR'S SIGNATURE <u>  </u>	

07503

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Black River - New York  
March 2, 1901 - 1902  
10503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7613  
CERTIFICATE OF DEATH

07604

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 30 Pleasant Hill Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 30 Pleasant Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Lucoy W. Gordon		4. DATE OF DEATH Month Day Year July 10, 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1880	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Winterode		14. MOTHER'S MAIDEN NAME Barbara Cross				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Walter M. Gordon Address Hydes, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - Chronic 443X DUE TO Decompensating Conditions, if any, which gave rise to immediate cause (b) Hypertension & atherosclerotic vessels (e), stating the underlying cause last. DUE TO The same (c) The same PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED - (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-30 to 7-10-61, that (I) (we) last saw the deceased alive on 7-9-61, 1961, and that death occurred at 3:38 PM, from the causes and on the date stated above.						
22a. SIGNATURE James G. Saffell 22c. PHYSICIAN'S NAME (Type)				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Reisterstown, Md.		22b. DATE SIGNED 7-11-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 61		23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		23d. LOCATION (City, town or county) (State) Reisterstown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3614  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07605

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>D. OF C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>0 MASONIC HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47X-3</b>	
4. DATE OF DEATH First Middle Last <b>CORA W. CARRICK GRAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-1870</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>DISTRICT OF COLUMBIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES CARRICK</b>		14. MOTHER'S MAIDEN NAME <b>SARAH GRIFFITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-14-1154</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b> Address <b>Cockeysville, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>3 years.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>10-1</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-1</b> , 19 <b>59</b> , to <b>7-24</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7-24</b> , 19 <b>61</b> , and that death occurred at <b>9:40 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Walter T. Kees</b> M.D.	
22b. DATE SIGNED <b>7/24/61</b>		22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>	
22d. ADDRESS <b>COCKEYSVILLE</b> <b>MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE THEREOF <b>7-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Baltimore</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>	
25a. REC'D BY REGISTRAR <b>JUL 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

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Mr. Cook, Inc., 1217 St. Paul Street, Room 2

Boston Park Cemetery

B. J. J. J.

7-26-61

2-26-61

James T. Cook

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7615

## CERTIFICATE OF DEATH

Reg. Dist. No. 07606

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Glyndon, Md</b>		c. LENGTH OF STAY IN 1b <b>3 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>----</b>		d. STREET ADDRESS <b>Geist Road</b>	
3. NAME OF DECEASED (Type or print) <b>Frank Green</b>		4. DATE OF DEATH <b>July 22 19 61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lee Green</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bumgardner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>414-20-6680</b>	
17. INFORMANT <b>Wife Mrs. Frank Green</b>		Address <b>Geist Road Glyndon Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditic Decompensating</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-16-61</b> to <b>7-22-61</b> , that I last saw the deceased alive on <b>7-16-61</b> , and that death occurred at <b>4 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>64 Main Street Reisterstown, Md.</b> DATE SIGNED <b>7-23-61</b>			
ACTUAL SIGNATURE <b>James G. Saffell</b>		M.D. <b>64 Main Street Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James G. Saffell Sr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/25/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James G. Saffell</b>		24a. REC'D BY REGISTRAR <b>JUL 26 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CERTIFICATE OF BIRTH

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7616

## CERTIFICATE OF DEATH

07607

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3yr11mth7dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cooksville</b>		d. STREET ADDRESS <b>Wood Chapel Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Henry Green</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Welding Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John H. Green</b>		14. MOTHER'S MAIDEN NAME <b>Clara TRIPLETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-09-6168</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> <b>bronchopneumonia</b> DUE TO (b) <b>uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>diabetes</b> DUE TO (c) <b>diabetes</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Long Standing</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 11, 1961</b> to <b>July 18, 1961</b> ; that (I) (we) last saw the deceased alive on <b>July 17, 1961</b> , and that death occurred at <b>1:40</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		22b. DATE SIGNED <b>7-18-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wards Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Parkway Road - Baltimore Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 24 '61</b>	
ADDRESS <b>Clydesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

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THREAT

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See attached

7-22-01 Change Order

Subject: Street Repaving

7/24/01

Page 1 of 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7617  
CERTIFICATE OF DEATH  
07608

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 22yrlmth29dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 514 SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3V01-4 h. STREET ADDRESS 27 S. Arlington Avenue i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Regina Middle Greenberg Last 4. DATE OF DEATH Month July Day 28 Year 19 61		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1887 9. AGE (In years last birthday) 74 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 11. BIRTHPLACE (County & State, or foreign country) Rumania 12. CITIZEN OF WHAT COUNTRY? Rumania	
13. FATHER'S NAME Milton Joseph Belbert 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive cirrhosis of the liver DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of the pancreas (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 5, 1961, to July 28, 1961, that (I) (we) last saw the deceased alive on July 28, 1961, and that death occurred at 11:15 A.M. from the causes and on the date stated above. 22a. SIGNATURE Aristides Simopoulos, M. D. 22b. DATE SIGNED 7-28-61 22c. PHYSICIAN'S NAME (Type) Aristides Simopoulos, M. D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July 30/61 23c. NAME OF CEMETERY OR CREMATORY Maryland Lodge 23d. LOCATION (City, town or county) (State) Rosedale, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sol. Levinson & Bros. Inc. 6010 Reist Road 25a. REC'D BY REGISTRAR DATE AUG 1 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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*Micrograph*

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7618  
CERTIFICATE OF DEATH

07609

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RIDGEWAY NURSING HOME</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>1 45 DUNMORE RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHANNA - GROARK</b>			4. DATE OF DEATH Month Day Year <b>JULY 16 1961</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 24, 1882</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BENCH WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELEC. CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>MICHAEL O'SULLIVAN</b>		
14. MOTHER'S MAIDEN NAME <b>BRIDGET MC GANN</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Name Address <b>Mary S. Price - 45 Dunmore Rd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Cardiovascular disease,</b> (b) <b>Generalized atherosclerosis.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While Not While et work <input type="checkbox"/> at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
2Df. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>July 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 14, 1961</b> , and that death occurred at <b>9:00</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>GEO. S.M. KIEFFER MD</b>			22b. DATE SIGNED <b>July 17, 61</b>		
22c. PHYSICIAN'S NAME (Type) <b>GEO. S.M. KIEFFER MD</b>			22d. ADDRESS <b>1010 Leeds Ave</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		23b. DATE THEREOF <b>7-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
23d. LOCATION (City, town or county)		(State) <b>Pittsburg, Penn.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Forley Cavenagh</b>			25a. REC'D BY REGISTRAR <b>B.F.H. - Catonsville, Md.</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			DATE <b>JUL 20 '61</b>		

107009

2012

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

*[Faint handwritten notes at the bottom of the page, including what appears to be a date "Jan 12 1912" and other illegible text.]*

7619

## CERTIFICATE OF DEATH

07610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bernoudy Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leah E. Grove</u>		4. DATE OF DEATH <u>July 1, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Bellefonte, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel C. Grove</u>		14. MOTHER'S MAIDEN NAME <u>Leah Stem m.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 30, 1961</u> to <u>July 1, 1961</u> , that I last saw the deceased alive on <u>June 30, 1961</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Farmtown, Md.</u> DATE SIGNED <u>7/3/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-5-61</u>	<u>Wesley Chapel Cem.</u>	<u>White Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>JUL 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

*[Faint, illegible handwritten text, likely a death certificate entry]*

(T)

*[Faint, illegible handwritten text, likely a death certificate entry]*



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FOR STATE  
HEALTH DEPT.

Delay is necessary. If delay is necessary, file with the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07611									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>511 Castle Drive</b>					d. STREET ADDRESS <b>511 Castle Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>MARK</b> Last <b>JAMES GRUBER</b>					4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1961</b>		9. AGE (In years last birthday) yrs. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Rignald R. Gruber, Jr.</b>					14. MOTHER'S MAIDEN NAME <b>Luba Strasdin</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family Records</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis.</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles S. Petty</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED <b>7/14/61</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>July 14, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>		
23. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>					24a. REC'D BY REGISTRAR DATE <b>JUL 17 '61</b>		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Thomas</i>		

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John Burns, Son, Towson, Maryland

Burial July 12, 1961 London Park Cemetery

Baltimore, Maryland

Charles E. Perry, Jr.

Wife

Infantile Paralysis

Home Home Family Records

Richard B. Gruber, Jr. Linda Strasdin

Home Baby

Maryland

USA

April 1, 1961

MARK WESS

July

13

13

311 Cassia Drive

311 Cassia Drive

Towson

Towson

Baltimore

Maryland

Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7622

07612

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 1535-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>12302 CHARLES AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>GERALD</u> Middle <u>KIRBY</u> Last <u>HALE</u>		4. DATE OF DEATH Month <u>7</u> - Day <u>4</u> - Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) yrs. <u>7</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES C HALE</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA SNYDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>150-034539</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>162.1</u> (c) <u>9 MONTHS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-4-1961</u> to <u>7-4-1961</u> , that (I) (we) lost the deceased on <u>7-4-1961</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm Newcomer</u>		22b. DATE SIGNED <u>7-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm Newcomer, M.D., Superintendent</u>		22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD - U.S.F.M.D.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.H. NEWELL INC. - Pikesville MD</u>		25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Cashin &amp; Thoms</u>			

MEDICAL CERTIFICATION

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10113

CERTIFICATE OF DEATH

10113

(M)

DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER OF THE GOSPEL  
SIGNATURE OF REGISTRAR

MADE IN  
9% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7621						07613					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Baltimore			MARYLAND			Md.			Baltimore		
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Arbutus			1228 Maple Ave.			Arbutus			1228 Maple Ave.		
9 Yrs.											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
George Leo Hall			July 6, 1961								
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 22, 1879		82 yrs.		1 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Carpenter Helper		B. & O. R.R.		Rochester, N. Y.		U. S.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Leo Hall				Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
no											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)										24 hrs.	
422.1 DUE TO Acute congestive heart failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1961, to July 6, 1961, that (I) (we) last saw the deceased alive on July 5, 1961, and that death occurred at 12:15 PM, from the causes and on the date stated above.											
22a. SIGNATURE Herbert J. Levickas M.D.										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas										22d. ADDRESS 5305 East Dine Baltimore 27 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			7-10-61			Loudon Park			Baltimore		
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Frederick Cole 1913 W. Balt. St.						JUL 10 '61			Arthur S. Frank		

61613

CHRONICLE OF DEATH

1933

(M)

Baltimore

No.

1933

Baltimore

1933

1933

1933

1933

1933

61

July

July

July

July

1933

1933

1933

1933

U. S.

U. S.

U. S.

U. S.

Unknown

Unknown

(I)

no

Baltimore

Baltimore

Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7623

## CERTIFICATE OF DEATH

07614

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7yr4mth16dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1832 Edgewood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Sophia</b> Middle <b>Mary</b> Last <b>Hardy</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>April 21, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>61</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Frederick Haussner</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia and renal failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Decubital gangrene</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 29, 19 61</b> to <b>July 22, 19 61</b> , that (I) (we) last saw the deceased alive on <b>July 21, 19 61</b> , and that death occurred <b>1210 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H.I. Cholmondeley</b>		22b. DATE SIGNED <b>7/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.I. Cholmondeley</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-25-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</b>		25. REC'D BY REGISTRAR <b>DATE JUL 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Clifford L. Farris</b>			

07614

2227

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1875 Eglwood Road

Bartholomew

Frederick H. H. H. H.

West to and from station

Intersecting with main line

Intersecting with main line

Intersecting with main line

1/2-1/2

x

*Handwritten signature*

H. J. O'Connell

New Catholic Cemetery

2-25-21

3001 N.

Book, Inc., 1517 N. 1st Street, Baltimore, Md. 21201

7624

## CERTIFICATE OF DEATH

Reg. Dist. No. 07615

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN TB <b>12 Wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House In The Pines</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Grace</b> Last <b>Harrison</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.		IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles Edward Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Laura Matthews</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Virginia Gauss-1913 Hillcrest Rd.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension C.V. disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cardiac Decompensation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>2 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 1, 1945</b> to <b>July 31, 1961</b> , that I last saw the deceased alive on <b>July 30, 1961</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6821 Reisterstown Rd. W. Baltimore, Md.</b> DATE SIGNED <b>7-31-61</b>							
ACTUAL SIGNATURE <b>M.W. Jacobson</b>				PHYSICIAN'S NAME (Type) <b>M.W. JACOBSON MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/2/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
87616														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN b <b>19 Days</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>O.</b> Last <b>HASTINGS</b>					4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 11, 1890</b>		9. AGE (In years last birthday) <b>70 yrs.</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery Shop</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								
13. FATHER'S NAME <b>Benjamin O. Hastings</b>					14. MOTHER'S MAIDEN NAME <b>Florence Hawkins</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW-1</b>					16. SOCIAL SECURITY NO. <b>216-05-9262</b>					17. INFORMANT <b>Clin Rec VAH Baltimore Md -Ft Howard Div</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), end (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS, SUPPURATIVE ILEUM</b> DUE TO <b>578X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c) <b>PERFORATION OF CECUM, CAUSE UNDETERMINED</b>										<b>UNKNOWN</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>July 10</b> , 19 <b>61</b> , to <b>July 29</b> , 19 <b>61</b> that <b>X</b> (we) last saw the deceased alive on <b>July 29</b> , 19 <b>61</b> , and that death occurred <b>9:05AM</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>7-29-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Joshua A. Smith</b> M.D.					22d. ADDRESS <b>VAH Baltimore 18 Md - Ft Howard Division</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>		23d. LOCATION (City, town or county) <b>Baltimore</b>		(State) <b>Maryland</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight Inc.</b>					25. REC'D BY REGISTRAR <b>AUG 1 '61</b>					25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>				

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Admission Administration Hospital

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August 11, 1890

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H.A.A.

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Barney Shop

John

Reference Building

Admission O. Building

210-05-2312 City Rec VAN Baltimore 10 - 10 Howard Ave

Ken W-1

UNKNOWN

REMARKS, SURVIVOR

UNKNOWN

INFORMATION RE DECEASED, CASE NUMBERED

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July 29

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July 10

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July 29

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7-29-01

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VAN Baltimore 10 10 - 10 Howard Division

H.A.

John A. Smith

myland

Baltimore

John A. Smith

8-1-21

Smith

60 9 Maryland Road

William Cook-Bright Inc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7625

07617

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 4</b> d. STREET ADDRESS <b>1648 Natura Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>JAMES L. HAWKINS</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>July 13 19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>September 1, 1897 63</b> yrs. Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Trucking</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Anne Arundel County</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>James Hawkins</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Morgan</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-18-5094</b>	
<b>17. INFORMANT</b> <b>Clinical Records, VAH,</b>		<b>Address</b> <b>Baltimore 18, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>THROMOSIS OF LEFT MIDDLE CEREBRAL ARTERY</b> 332X DUE TO <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INFARCTION OF MYOCARDIUM - Duration Unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>UNKNOWN</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>June 28 1961 to July 13 1961</b>
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <b>June 28 1961</b> to <b>July 13 1961</b> that (X) (we) last saw the deceased alive on <b>July 13 1961</b> and that death occurred at <b>p.m.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i> <b>THOMAS F. CRAHAN, M.D.</b>		<b>22b. DATE SIGNED</b> <b>7/14/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>		<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7-16-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baldwin Memorial</b>	<b>23d. LOCATION (City, town or county)</b> (State) <b>Millersville, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 18 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thomas</i>			

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REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION OF THE  
BOARD OF LAND OFFICIALS  
PASSED AT A MEETING  
HELD AT WASHINGTON, D.C.  
ON MAY 1, 1900  
IN RESPONSE TO A  
RESOLUTION OF THE  
BOARD OF LAND OFFICIALS  
PASSED AT A MEETING  
HELD AT WASHINGTON, D.C.  
ON MAY 1, 1900

REPORT OF THE COMMISSIONER OF THE BUREAU OF THE LAND OFFICE

THE LAND OFFICE  
WASHINGTON, D.C.  
JUNE 1, 1900  
TO THE BOARD OF LAND OFFICIALS  
WASHINGTON, D.C.  
IN RESPONSE TO A  
RESOLUTION OF THE  
BOARD OF LAND OFFICIALS  
PASSED AT A MEETING  
HELD AT WASHINGTON, D.C.  
ON MAY 1, 1900

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7627

Item 6, Telephone call Holland Fun. Home 8/4/61 enc.

07618

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>X Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Cargil Ave.</b>		d. STREET ADDRESS <b>18 Cargil Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>(NMI)</b> Last <b>Hebron</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b> <b>July 5, 1961</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Wade</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Panking</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>11-11-11-11-11</b>	
17. INFORMANT <b>Eugene F. Wade</b>		Address <b>8 Cargil Ave. Catonsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b> <b>17 4 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>13 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12 Dec 1955</b> to <b>23 July 1961</b> that (I) (we) lost saw the deceased alive on <b>23 July 1961</b> , and that death occurred on <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>O. R. Davidson</b>		22b. DATE SIGNED <b>26 July 61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 31 '61</b>	
ADDRESS <b>1631 Druid Hill Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Thomas</b>	

10218

RECEIVED

10218



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07619

FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7 ENSOR AVE</b>		c. LENGTH OF STAY IN lb <b>40 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>TOWSON MD.</b>				d. STREET ADDRESS <b>17 ENSOR AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>HINTON</b> Last <b>HINTON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 1, 1888</b>	9. AGE (In years last birth day) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GARDENER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Families</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GOLUS HINTON</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hinton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>JAMES N. HINTON TOWSON</b>		Address <b>TOWSON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 YRS.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Timothy M. Hinton, BALTO.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/12/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest TOWSON BALTO. CO. MD.</b>		22d. LOCATION (City, town, or country) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR <b>Wm. L. Galtman</b>				24a. REC'D BY REGISTRAR <b>10 10 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hinton</b>	

Baltimore

212

2022 MEDICAL EXAMINER CERTIFICATE OF QUALIFICATION

(M)

(I)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7629

## CERTIFICATE OF DEATH

07620

Item 2 Film 8292 7/2/61 ink

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore City</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Md.</u> d. STREET ADDRESS <u>2715 Guilford Avenue</u> <u>3V014</u>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>(Mrs.) Catherine E. Hobbs</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>July 27 19 61</u>							
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11/31/1872</u>		<b>9. AGE (In years lost birthday)</b> <u>88</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hswf.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Baltimore, Md.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>American</u>			
<b>13. FATHER'S NAME</b> <u>Nicholas Fisher</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Ann Keim</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Alice R. Fisher 2715 Guilford Ave.,</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Phosphorus Tox. Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>ASCVD</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 30, 1961</u> <u>7:27 PM</u> <b>to</b> <u>July 27, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>7/27, 1961</u> <b>and that death occurred at</b> <u>7:27 PM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>(M. Mahon, M.D.)</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>7/27/61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Robert Mahon</u>						<b>22d. ADDRESS</b> <u>602 E. Joppa Rd., Towson-4, Md</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7/29/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>				<b>23d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Maryland</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook - Towson, Inc 1050 York Road</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUL 31 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Harris</u>			

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Baltimore, Maryland

Woodlawn Cemetery

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Mr. Cook - Towson, Inc. 10000 York Road

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**  
e. COUNTY **BALTIMORE** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **BALTIMORE 12**  
c. LENGTH OF STAY IN 1b **11 MOS**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **48 MURDOCK RD**

2. **USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)  
e. STATE **MD** b. COUNTY **BALTIMORE**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **BALTIMORE 12**

d. STREET ADDRESS **48 MURDOCK RD** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) **HENRIETTA EMMA HOFFMAN** 4. **DATE OF DEATH** Month **JULY** Day **4** Year **1961**

5. SEX **F** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **APRIL 1 1883** 9. AGE (in years last birthday) **78** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10b. KIND OF BUSINESS OR INDUSTRY **—** 11. BIRTHPLACE (County & State, or foreign country) **BALTIMORE CITY, MD.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **CHARLES SCHILDWACHTER** 14. MOTHER'S MAIDEN NAME **WILHELMINA VOELTER**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **—** 17. INFORMANT Address **MRS. ELIZABETH H. LEHR, 48 MURDOCK RD, BALTIMORE, MD.**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **CARCINOMA OF BLADDER**  
**181.0** DUE TO  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)

INTERVAL BETWEEN ONSET AND DEATH  
**1 YEAR**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (the hospital) attended the deceased from **JUNE 19 61** to **JULY 4 1961**, that (I) (we) last saw the deceased alive on **JULY 3 1961**, and that death occurred **5:00 P.M.** from the causes and on the date stated above.

22a. SIGNATURE **William A. Pilusbury** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **7-4-61**

22c. PHYSICIAN'S NAME (Type) **WILLIAM A. PILUSBURY** 22d. ADDRESS **2060 YORK**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **7/8/61** 23c. NAME OF CEMETERY OR CREMATORY **London Park** 23d. LOCATION (City, town or county) (State) **Baltimore**

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Wm. J. Zickler & Sons Balto. 17, Md.** 25a. REC'D BY REGISTRAR DATE **JUL 7 '61** 25b. REGISTRAR'S SIGNATURE **Charles L. Thomas**

(M)

(I)

Part 1

Part 2

Part 3

Part 4

Part 5

Part 6

Part 7

Part 8

Part 9

Part 10

Part 11

Part 12

Part 13

Part 14

Part 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
7631 CERTIFICATE OF DEATH 07622											
Items 3, 8, 9 & 23b Film 0292 7/31/61 ink											
1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>				d. STREET ADDRESS <b>200 E. Franklin Ave</b>							
3. NAME OF DECEASED (Type or print) <b>(Annie) First Middle Last Anna C. HOMMERBOCKEN</b>				4. DATE OF DEATH Month Day Year <b>7-25-1961</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 12, 1878</b>		9. AGE (In years last birthday) <b>82</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. MD.</b>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Harry Kestler</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FAMILY</b>		Address <b>Same</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>July 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 24, 1961</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/26/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		23b. DATE THEREOF <b>July 29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Landon PK Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. MD.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully Fun. Home, Balto. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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CERTIFICATE OF DEATH

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7708 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07693

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catersville 28 Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St Joseph's Nursing Home</u>		d. STREET ADDRESS <u>1322 Tuquett Rd. 28 md</u>	
3. NAME OF DECEASED (Type or print) <u>SR. M. HONORATA</u>		4. DATE OF DEATH <u>July 20 1961</u>	
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>70</u> yrs.
13. FATHER'S NAME <u>Adam Orłowski</u>		14. MOTHER'S MAIDEN NAME <u>Poulina ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sister Mary Eugene 1222 Tuquett Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Sanguine left leg</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3 1961</u> to <u>July 20 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. Rowe M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u>		22d. ADDRESS <u>1011 Frederick Road, 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>July 22 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederic W. OZAZENSKI</u>		25a. REC'D BY REGISTRAR <u>24 '61</u>	
ADDRESS <u>1930 EASTERN</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Perna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *Jan 15 1900*  
5. Date of death: *Dec 10 1945*  
6. Place of death: *Home*  
7. Cause of death: *Heart disease*  
8. Signature of physician: *J. H. Smith*  
9. Signature of registrar: *A. B. Jones*  
10. Date of registration: *Dec 15 1945*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07623											
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville					c. LENGTH OF STAY IN 1b 9 Years						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. STREET ADDRESS Powers Avenue						
3. NAME OF DECEASED (Type or print) JAMES <del>XXXXXXXX</del> TAYLOR HOWARD TAYLOR					4. DATE OF DEATH Month Day Year July 21 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7 1916		9. AGE (In years last birthday) yrs. 45			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Taylor Howard					14. MOTHER'S MAIDEN NAME Myrtle Findley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. W.W. 2 213 05 7322		17. INFORMANT Barbara Howard (wife) Cockeysville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Gunshot Wound of Head Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause lost. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self in head with 22 cal. rifle						
20c. TIME OF INJURY Hour e.m. 11:30 AM Month, Day, Year 7-21 1961					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rear of upholstery shop Cockeysville, Md.					20f. (City or town) (County) (State) Balto. Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. V. Lovitt, Jr.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) WILLIAM V. LOVITT, Jr.,					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
					DATE SIGNED July 22, 1961						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7/24/1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland.		
23. FUNERAL DIRECTOR Brooks Funeral Ser. 622 York Rd. Md.					24a. REC'D BY REGISTRAR DATE JUL 26 '61					24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

M

Charles Wood of Hall

Wm. Wood

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 7633  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 07624

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Arbutus)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1217 Maiden Choice La.</b>		d. STREET ADDRESS <b>1217 Maiden Choice Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>McKinsey</b> Last <b>Hunt</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1894</b>
9. AGE (In years lost birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Levin S. Hunt</b>		14. MOTHER'S MAIDEN NAME <b>Barteena Bromme</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>218-26-0648</b>	
17. INFORMANT <b>Florence Hunt</b>		Address <b>1217 Maiden Choice La. #29</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) <b>Complete heart block</b> <b>Atrio-ventricular block</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hour?</b> <b>6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>5.18.1960</b> to <b>7.19.61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>7.17.1961</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>George E. Urban</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Urban, M. D.</b>		22d. ADDRESS <b>805 Frederick Ave. #28</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>JUL 24 '61</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

1. Name of deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of birth: [Illegible]  
5. Date of death: [Illegible]  
6. Place of death: [Illegible]  
7. Cause of death: [Illegible]  
8. Signature of physician: [Illegible]  
9. Signature of registrar: [Illegible]  
10. Date of registration: [Illegible]



## CERTIFICATE OF DEATH

Reg. Dist. No.

07625

7634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7815 Daniels Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>K</b> Last <b>HUPFELD</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1874</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Diesroth</b>		14. MOTHER'S MAIDEN NAME <b>Anna Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Howard Hupfeld</b>		Address <b>7815 Daniels Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rt. Hemiplegia due to Cerebral Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1961, to <b>July 22</b> , 1961, that I last saw the deceased alive on <b>July 22</b> , 1961, and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen Toms, M.D.</b>		ADDRESS (Street, city or town, state) <b>4510 Bowleys Lane</b>	
PHYSICIAN'S NAME (Type) <b>STEPHEN TOMS, M.D.</b>		DATE SIGNED <b>Baltimore 6, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 25, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>		ADDRESS <b>Baltimore Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07698											
1. PLACE OF DEATH e. COUNTY <b>BALTO</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VILLA JULIE</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STEVENSON</b> g. STREET ADDRESS <b>1 VALLEY ROAD.</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SISTER AGNES OF THE TRINITY (HURLEY)</b>						4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>1961</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 16, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES J. HURLEY</b>						14. MOTHER'S MAIDEN NAME <b>MARY BRENNAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>---</b>					
17. INFORMANT <b>Sister Mary Patrick-Villa Julie</b>						Address <b>---</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>442X</b> <b>Cardio-renal vascular disease</b>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arteriosclerosis.</b>											
(c) <b>Degenerative disease</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour e.m. <b>---</b> p.m. <b>---</b>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>May 12, 1961</b> to <b>July 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>29 June 1961</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Harold H. Burns</b> M.D.											
22b. DATE SIGNED <b>7-2-61</b>											
22c. PHYSICIAN'S NAME (Type) <b>---</b>											
22d. ADDRESS <b>115 E. EAGER - St.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE THEREOF <b>7-3-61</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>											
23d. LOCATION (City, town or county) (State) <b>St. Charles, Md.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Foley-Cavanaugh</b> ADDRESS <b>714 P. Catonsville, Md.</b>											
25a. RECEIVED BY REGISTRAR <b>---</b> DATE <b>7-10-61</b>											
25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>											

01603

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7635

07626

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>- WOODLAWN</b>		c. LENGTH OF STAY IN 1b <b>10 YEARS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2034 RUSSELL AVE</b>		d. STREET ADDRESS <b>2034 Russell Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>VENOY</b> Last <b>HURTT</b>		4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/89</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STRUCTURAL IRON WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- STEEL</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWSON P. HURTT</b>		14. MOTHER'S MAIDEN NAME <b>LYDIA FALLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-4096</b>	
17. INFORMANT <b>WIFE - MRS. HURTT</b>		Address <b>2034 RUSSELL AVE BALTO. 7, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>HYPERTENSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DEGENERATIVE HEART DISEASE</b> DUE TO (c) <b>CARCINOMA PROSTATE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b> <b>3 YEARS</b> <b>3 1/2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/10</b> 19 <b>61</b> to <b>7/3</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/3</b> 19 <b>61</b> , and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwin L. Pierpont</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>		22d. ADDRESS <b>8204 LIBERTY RD. - BALTO. 7, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 8, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		25a. REC'D BY REGISTRAR <b>JUL 10 61</b>	
ADDRESS <b>6411 Windsor Mill Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

13770

CERTIFICATE OF DEATH

(M)

(1)

MADE IN U.S.A.

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7636

07627

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		d. STREET ADDRESS <b>Formerly of 1837 W. Baltimore St</b> <b>Paradise Nursing home</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Marietta E. Irvin</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>July 23/61 19</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 10/83</b>
<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Theodore Chaney</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> Address <b>WM. J. Irvin, Paradise Nurs. Home, Catonsville</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>malnutrition</b> <b>450.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> (c) <b>Sensibility</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 1955 to 7.33. 1961, that (I) (we) last saw the deceased alive on 7.33. 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Stanley Ankudars</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>STANLEY ANKUDARS</b>		<b>22d. ADDRESS</b> <b>1802 W. Baltimore, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>7/26/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Pk.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Balto. Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Witzke F.D. 4101 Edmondson Ave</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUL 26 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>			

(M)

17336

CERTIFICATE OF DEATH

17336

Half born

Stationville

Stationville

Stationville, Kentucky  
Born: 1892  
Died: 1912

Stationville, Kentucky

Stationville, Kentucky

Stationville, Kentucky

18

1892

Stationville, Kentucky

Stationville, Kentucky

Stationville, Kentucky

Stationville, Kentucky

Stationville, Kentucky

Stationville, Kentucky  
Born: 1892  
Died: 1912

Stationville, Kentucky

Stationville, Kentucky

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7637  
07628  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> c. LENGTH OF STAY IN 1b <b>10 RIDGE RD.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10 RIDGE RD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>110 RIDGE RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR V. L. JAMES</b>		4. DATE OF DEATH Month Day Year <b>JULY 14 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 19, 1900</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL ENGINEER-RET. D.O. RR.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>WALTER M. JAMES</b>	
14. MOTHER'S MAIDEN NAME <b>ALLIE A. GUIBERT</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give year or dates of service) <b>W.W. I &amp; II</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Walter E. James - 1544 Kirkwood Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic CVD</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>July 7, 1961</b> to <b>7/14, 1961</b> , that (I) (the hospital) last saw the deceased alive on <b>7/7, 1961</b> , and that death occurred at <b>7A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>James Nolan</b> M.D. 22b. DATE SIGNED <b>7/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. J. NOLAN</b>		22d. ADDRESS <b>Baltimore 29, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-17-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tracy Caraway D.F.H. - Catonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles E. Harris</b>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <b>JUL 20 '61</b>	

17883

17883

M

1

Handwritten notes, mostly illegible due to bleed-through from the reverse side. Some words like "WATER" and "STATION" are faintly visible.

Handwritten notes, mostly illegible due to bleed-through from the reverse side. Some words like "STATION" and "WATER" are faintly visible.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7638

07629

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>Cockeysville</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Happy Hollow Road</u>		d. STREET ADDRESS <u>Happy Hollow Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Amanda</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 25, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Lois <sup>41</sup> Parks</u>		Address <u>Happy Hollow Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Some years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>60</u> , to <u>July</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> 19 <u>61</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill</u>		22b. DATE SIGNED <u>7/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 22, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fork M E</u>		23d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u>		25a. REC'D BY REGISTRAR <u>Jul 21 '61</u>	
ADDRESS <u>1050 York Rd. Towson, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1972

07528

My wife, Mary, died

at her home

on January 2, 1972

at the age of 68

known

known

My wife, Mary, died

at her home

on January 2, 1972

at the age of 68

known

known

known

known

known

known

known

known

known

known



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07630

7639

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>X Dundalk (22)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewall Beach-Bear Creek Road</b>				d. STREET ADDRESS <b>3004 Dunmurry Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LANE CRAWLEY JONES</b>				4. DATE OF DEATH Month Day Year <b>July 1st, 1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1937</b>	
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Robert C. Jones, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Ballard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 56-58</b>				16. SOCIAL SECURITY NO. <b>213-34-4234</b>		17. INFORMANT Address <b>R.C. Jones, Jr., Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning - Accidental</b> <b>850 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from stern of boat.</b>			
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>June 30, 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>	
20f. (City or town) <b>Bear Creek</b>				(County) <b>Baltimore</b>		(State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>7/3/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR <b>DATE 11 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. K. K. K.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7640

## CERTIFICATE OF DEATH

Reg. Dist. No. 07631

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chattalonnee</b>		c. LENGTH OF STAY IN 1b <b>X Chattalonnee</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley Road</b>		d. STREET ADDRESS <b>Valley Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JONES</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wyeth</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Riley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Annie Sterret Valley Road.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis &amp; hardening of arteries</b> DUE TO (c) <b>arteriosclerosis &amp; hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 12, 1940</b> to <b>July 23, 1961</b> , that I last saw the deceased alive on <b>July 22, 1961</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Palmer F. C. Williams</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>ownip Mills, Md. July 24, 1961</b>	
PHYSICIAN'S NAME (Type) <b>Palmer F. C. Williams</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-26-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reistertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Matthew C. Hensley</b>		24a. REC'D. BY REGISTRAR <b>JUL 27 1961</b>	
ADDRESS <b>5784</b>		24b. REGISTRAR'S SIGNATURE	

## 45

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2000.

ASSOCIATE

CERTIFICATE OF DEATH

7641

07632

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>66 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>810 North Gilmore Street (17)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Served as First Middle Last) NINEAVAH HOWARD JONES JONES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1893</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>10</b> Hours <b>19</b> Min. <b>61</b>	11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Prospect, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Jones</b>		14. MOTHER'S MAIDEN NAME <b>Sarah MN: Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-14-6756</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>CARCINOMA OF LIVER WITH METASTASES TO PERITONEUM AND REGIONAL LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CHRONIC PYELONEPHRITIS WITH CALCULI</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS. BENIGN PROSTATIC HYPERTROPHY</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>May 5</b> <b>1961</b> to <b>July 10</b> <b>1961</b> , that <b>11:20</b> (we) last saw the deceased alive on <b>July 10</b> <b>1961</b> , and that death occurred at <b>11:20</b> <b>PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Crahan</b> 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22b. DATE SIGNED <b>7/12/61</b> 22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>7-15-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ferguson Family</b>	23d. LOCATION (City, town or county) (State) <b>Farmville Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave. Balto. 17, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 19 61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH.

SHIPPED TO: Rand & Reid Funeral Home, Farmville, Virginia





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07633

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>12 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Ave. &amp; Milford Mill Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fred W.</b> Middle <b>Kahle</b> Last <b></b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 26, 1911</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coremaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin's</b>	
11. BIRTHPLACE (State or foreign country) <b>Oldstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Kahle</b>		14. MOTHER'S MAIDEN NAME <b>Eliza beth Kleckner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>184-10-1988</b>	
17. INFORMANT <b>Margaret Kahle</b>		Address <b>4806 Laurel Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (a), stating the underlying cause lost. DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs. (est)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>none</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>7-24-61</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Blvd. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Farace Inc.</b>		ADDRESS <b>712-14 E. North Ave.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 24 61</b>		24b. REGISTRAR'S SIGNATURE <b>James E. Frank</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7643

07634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>938 Wilton Drive</b>		e. STREET ADDRESS <b>938 Wilton Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna E. Karaskevitch (also Karas)</b>		4. DATE OF DEATH Month Day Year <b>July 25, 19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1884</b>
9. AGE (In years last birthday) <b>76 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>LITHUANIA</b>	
13. FATHER'S NAME <b>? Lukasaitis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Albert Karas 938 Wilton Drive, Balto. 27, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute Cardiac Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis Cardiovascular</b> DUE TO <b>10yr</b> (c) <b>10yr</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 da</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> to <b>7/25</b> , that (I) (we) last saw the deceased alive on <b>7/25</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph G. Laukaitis MD</b>		22b. DATE SIGNED <b>7/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph G. Laukaitis, M. D.</b>		22d. ADDRESS <b>679 Washington Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 27 '61</b>	
ADDRESS <b>4107 Wilkens Avenue #29</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinner</b>	

CERTIFICATE OF DEATH

7553



1. Name of deceased: JAMES H. KELLY (also known as)  
2. Date of birth: 1901, 10, 10  
3. Date of death: 1950, 10, 10  
4. Place of death: [illegible]  
5. Cause of death: [illegible]  
6. Signature of physician: [illegible]  
7. Signature of registrar: [illegible]  
8. Date of registration: 1950, 10, 10  
9. Place of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1 Maryland State Department of Health

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7644

## CERTIFICATE OF DEATH

07635

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1yr10mth23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4607- 29th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Roy</b> Last <b>Kelley</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records : SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 26, 1961</b> to <b>July 11, 1961</b> that (I) (we) last saw the deceased alive on <b>July 11, 1961</b> , and that death occurred at <b>2M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslor</b>		22b. DATE SIGNED <b>7-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation 7/12/61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Waynesboro</b>		23d. LOCATION (City, town, or county) (State) <b>Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Faschi</b>		25b. REGISTRAR'S SIGNATURE <b>REC'D BY REGISTRAR M.D. JUL 14 '61</b>	

0-133

CERTIFICATE OF DEATH

1914

14

CHIEF OF BUREAU



7645

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07636

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home</b>				d. STREET ADDRESS <b>4029 Wilkens Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ann Josephine Kelly</b>				4. DATE OF DEATH Month Day Year <b>July 4, 1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1880</b>		9. AGE (In years less birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael J. Caton</b>				14. MOTHER'S MAIDEN NAME <b>Ann O'Connor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Wm. H. Kelly 4033 Wilkens Ave. #29 (son)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accid.</b> DUE TO (b) <b>Atherosclerotic vascular dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>—</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>— 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State) <b>— — —</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>January 1961</b> to <b>July 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 4, 1961</b> , and that death occurred <b>at 10:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Christian S. Mass</b>				22b. DATE SIGNED <b>7/6/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Christian S. Mass, M. D.</b>				22d. ADDRESS <b>413 Nottingham Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Maryland</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 7 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Mass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1st of January 1901  
General Sir John Durnford

1st of January 1901  
General Sir John Durnford

1st of January 1901  
General Sir John Durnford

1st of January 1901  
General Sir John Durnford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7646

CERTIFICATE OF DEATH

07637

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>16 Fursting Avenue</b> <b>House in the Pines Nursing Home</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Woodmoor)</b> d. STREET ADDRESS <b>3502 Hillsmere Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Beulah E. King</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>1</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>November 11, 1885</b> <b>75</b> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>?</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Mr. Roland Whitaker-3502 Hillsmere Road</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease, enlarged heart,</b> <b>415X</b> DUE TO <b>myocardial insufficiency.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis, advanced</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>2Db. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>	<b>2Dd. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>2De. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>2Df. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11-15</b> , 19 <b>56</b> , to <b>7-1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>6-19</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>B. Stanley Cohen</b> <b>M.D.</b>		<b>22b. DATE SIGNED</b> <b>7-3-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>B. STANLEY COHEN</b>		<b>22d. ADDRESS</b> <b>7306 Liberty Rd Balto 7 Md</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7-3-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Yon J. Zechner &amp; Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 3 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>	

17837

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1-1-61

1-1-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7647

CERTIFICATE OF DEATH

07638

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1932 Cedar Lane</b>		d. STREET ADDRESS <b>1932 Cedar Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>KNAUER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 8, 1913</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Knauer</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Soupe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Margaret Griffin 1932 Cedar Lane</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA WITH METASTASES</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 20, 1960</b> , to <b>20 JULY 1961</b> , that (I) (we) last saw the deceased alive on <b>20 JULY 1961</b> , and that death occurred <b>2:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>U. E. Baermann, M.D.</b>		22b. DATE SIGNED <b>20 JULY 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>U. E. Baermann</b>		22d. ADDRESS <b>3401 Dundalk Avenue Dundalk 22, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

1847

CERTIFICATE OF DEATH

1847

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7648  
7648  
07639

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore 24 d. STREET ADDRESS 507 South 47th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL E. KOLAKOWSKI		4. DATE OF DEATH Month Day Year July 10 19 61				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1900	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Constant Kolakowski		14. MOTHER'S MAIDEN NAME Lucille Kolakowski				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes. WW I		16. SOCIAL SECURITY NO. 214-14-3517		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) MULTIPLE MYELOMA 203X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from June 30 1961 to July 10 1961, that (X) (we) last saw the deceased alive on July 10 1961, and that death occurred at 8:40 A.M. from the causes and on the date stated above.						
22a. SIGNATURE Thomas F. Crahan M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/10/61		
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles D. Sadowski		ADDRESS 1937 Gough St., Balto. 31, Md.		25a. REC'D BY REGISTRAR JUL 13 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines

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REPLY

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7645

07640

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN <b>2 wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mt. Wilson Lane, Pikesville 8, Md.</b>				d. STREET ADDRESS <b>Mt. Wilson Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nellie Julia Kranz</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 8, 1881</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>		IF UNDER 24 HRS. Hours <b>80</b> Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ulrich Nickel</b>				14. MOTHER'S MAIDEN NAME <b>Julia Lappe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/branch of service) <b>No None</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Mr. William L. Kranz</b>				Address <b>Pikesville 8, Md. Mt. Wilson Lane,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>entire</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D.D. Caples</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. D.D. Caples, Reisterstown, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <b>Dr. D.D. Caples, Reisterstown, Md.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville 8, Md.</b>				24a. REC'D BY REGISTRAR <b>Arthur E. Thomas</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7650

07641

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>102 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (6)</b> d. STREET ADDRESS <b>6921 Beech Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>FREDERICK</b> Middle <b>M.</b> Last <b>LANCE</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>18</b> Year <b>1961</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 20, 1916</b>	<b>9. AGE (In years last birthday)</b> <b>45 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Liquor</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Overlea, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>William Lance</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances C. Eberly</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220-03-0877</b>		<b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LUNG ABSCESS, LEFT LUNG</b> (b) <b>BRONCHOPNEUMONIA, BILATERAL</b> (c) <b>CARCINOMA, SOFT PALATE WITH METASTASES TO CERVICAL LYMPH NODES, HEART, DIAPHRAGM, LIVER AND KIDNEY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <b>e.m.</b> Month, Day, Year <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 7, 1961</b> to <b>July 18, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 18, 1961</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Thomas F. Crahan</b>		<b>22b. DATE SIGNED</b> <b>7/19/61</b>	<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>				
<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7-22-1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) <b>Baltimore, Maryland</b>	<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lassahn Funeral Home, 7401 Belair Road, Balto. 6,</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 21 '61</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Huns</b>				

Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



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7651

## CERTIFICATE OF DEATH

Reg. Dist. No. 07642

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b>				c. LENGTH OF STAY IN 1b <b>14 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2501 E. Joppa Rd.</b>				d. STREET ADDRESS <b>12501 E. Joppa Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>LANKFORD, Sr.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1892</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William O. Lankford</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Heim</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>212-05-4615</b>			
INFORMANT <b>George W. Lankford Jr.</b>				Address <b>Same.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>182.01</b> DUE TO <b>Bronchogenic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Wide spread Pulmonary Infiltration</b> (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>approx 10 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 19 60</b> to <b>28 July 19 61</b> , that I last saw the deceased alive on <b>25 July 19 61</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John C. Hyle</b>				ADDRESS (Street, city or town, state) <b>7527 Belair Rd.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN C. HYLE M.D.</b>				DATE SIGNED <b>7-28-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-31-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PK</b>		22d. LOCATION (City, town or county) (State) <b>BALTO CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. EVANS, SON</b>				ADDRESS <b>8802 NORTON RD</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 31 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7652

CERTIFICATE OF DEATH

07643

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Balto Co.</i> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chase - Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chase. Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Rt-14-Box 24 V. Eastern Ave</i>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Mary</i> Middle <i>Lawrence</i> Last		<b>4. DATE OF DEATH</b> Month <i>July</i> Day <i>22</i> Year <i>1961</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W.</i> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. B. DATE OF BIRTH <i>Sept 8 - 1861</i>		8. AGE (In years last birthday) <i>99</i> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Balto Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Tutchton</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Christian Lawrence</i>		Address <i>Balto Co Md.</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-Vascular accident</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardio-Vascular disease</i> DUE TO (c) <i>10-yr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1 - 1961</i> to <i>July 22, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 21, 1961</i> , and that death occurred at <i>8:40 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>G.M. Baumgardner</i> M.D.		22b. DATE SIGNED <i>7/24/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>G.M. Baumgardner</i>		22d. ADDRESS <i>Balto Co Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>Benezer Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Balto Co Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>		25a. REC'D BY REGISTRAR <i>DATE 2 6 '61</i>	
ADDRESS <i>Baltimore</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1943

RECEIVED

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 7653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07644

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8041 MISHAVEN RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Lee Lea</u>		4. DATE OF DEATH Month Day Year <u>July 29 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1896</u> <u>July 19, 1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>Thomas Lea</u>		14. MOTHER'S MAIDEN NAME <u>Alma Wallington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>225-05-5100</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		DATE SIGNED <u>7-30-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Balto Co</u>	
23. FUNERAL DIRECTOR <u>Wilbur Funeral Home</u>		24a. REC'D BY REGISTRAR <u>AUG 2 '61</u>	
ADDRESS <u>2112 Dundalk</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. S. Kline</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-2111  
100-2111



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7654

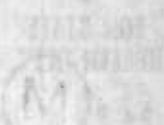
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07645

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> <b>Behind Towson Diner, 718 York Rd. Towson, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>1107 S. Charles Street, Baltimore</i>	
3. NAME OF DECEASED (Type or print) <b>JAMES LENGARIS</b>		4. DATE OF DEATH <b>July 1 1961</b>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-26-04</i>
9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Diner</i>	
11. BIRTHPLACE (State or foreign country) <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michel Lengaris</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>William V Lovitt m.p.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound of head</i> <i>976X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>1:00</i> a.m. Month, Day, Year <i>July 1 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Parking lot</i>		20f. (City or town) <i>Towson</i> (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 1 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Charles Evans Em. Reading Pa</i>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <i>Calloway &amp; Son</i>		24a. REC'D BY REGISTRAR <i>July 5 '61</i>	
ADDRESS <i>4600 Belair Ave</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1000

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250



TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

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[illegible text block]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7655

CERTIFICATE OF DEATH

Item 2 Film G292 8/4/61 ink

07646

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 15, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>133 Slade Ave. Professional House</b>				d. STREET ADDRESS <b>6607 Park Heights Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>LEVY</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1871</b>	
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Israel Cohen</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>		17. INFORMANT <b>Dr. Charles S. Levy- 3501 St. Paul Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED ARTERIO SCLEROSIS</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MYOCARDIAL DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1961</b> to <b>JULY 27, 1961</b> , that (I) (we) lost saw the deceased alive on <b>JULY 27, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Daniel J. Schwartz</b> M.D.				22b. DATE SIGNED <b>7/27/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DANIEL J. SCHWARTZ, M.D.</b>				22d. ADDRESS <b>2320 EUTAW PLACE BALTO. MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 30/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc.</b>				25a. REC'D BY REGISTRAR <b>AUG 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

1944

CERTIFICATE OF DEATH

1944

(M)

(1)



TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

FOR STATE  
HEALTH DEPT.

1  
M  
I  
X  
2

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07647

1. PLACE OF DEATH a. COUNTY Warren Road - Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN lb None	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Warren Road		d. STREET ADDRESS 307 S. Broadway Balto, 31, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last LETTY L. LINGERIS		4. DATE OF DEATH Month Day Year July 1st. 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19th. 1909
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Davis Co. Lexington N.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Uley Crotts		14. MOTHER'S MAIDEN NAME Lottie Musgrave	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Robert Brooke		Address 307 S. Broadway Zone 31	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982X Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Multiple stab wounds (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 1, 1961 Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/2/61	
22c. NAME OF CEMETERY OR CREMATORY Davidson Piedmont Funeral Home		22d. LOCATION (City, town, or country) (State) Davis Co. Lexington N.C.	
23. FUNERAL DIRECTOR Wm. S. Fraltrowski		24a. REC'D BY REGISTRAR DATE 3 '61	
ADDRESS 2007 Eastern Ave Zone 31 Baltimore		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

3888

RECEIVED - MEDICAL EXAMINERS CENTRAL OF DEATH

Name - <u>John Doe</u>		Age - <u>35</u>		Sex - <u>Male</u>	
Date of Birth - <u>1945</u>		Place of Birth - <u>USA</u>		Occupation - <u>Engineer</u>	
Address - <u>123 Main St, City, State</u>		Phone - <u>555-1234</u>		Religion - <u>Protestant</u>	
Marital Status - <u>Married</u>		Spouse Name - <u>Jane Doe</u>		Spouse Address - <u>456 Oak St, City, State</u>	
Education - <u>High School</u>		Military Service - <u>None</u>		Previous Injuries - <u>None</u>	
Current Health - <u>Good</u>		Allergies - <u>None</u>		Medications - <u>None</u>	
Cause of Death - <u>Heart Attack</u>		Time of Death - <u>10:00 AM</u>		Place of Death - <u>Home</u>	
Witnesses - <u>John Doe, Jane Doe</u>		Coroner - <u>John Doe</u>		Medical Examiner - <u>John Doe</u>	
Signature of Coroner - <u>[Signature]</u>		Signature of Medical Examiner - <u>[Signature]</u>		Signature of Witness - <u>[Signature]</u>	
Date of Report - <u>July 1, 1980</u>		Time of Report - <u>10:00 AM</u>		Place of Report - <u>Home</u>	
Remarks - <u>Heart Attack</u>		Remarks - <u>Heart Attack</u>		Remarks - <u>Heart Attack</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7657 CERTIFICATE OF DEATH

Reg. Dist. No.

07648

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Villa Maria, Notch Cliff</b>		d. STREET ADDRESS <b>Glenarm, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Modesta</b> Middle <b>Little</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-1892</b>
9. AGE (In years last birthday) <b>68 69/100</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teaching</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis</b>		14. MOTHER'S MAIDEN NAME <b>Louise Lange</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sister M. Henrica</b>		Address <b>Villa Maria Glenarm, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis--Cardio-Renal vas.dis.</b> 10 yrs. (c) <b>Diabetes</b> 20 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> 19 <b>61</b> , to <b>July 15</b> 19 <b>61</b> , that I last saw the deceased alive on <b>July 11</b> 19 <b>61</b> , and that death occurred at <b>10:45M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road, Towson 4</b> DATE SIGNED			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-17-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF RT Towson, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Seiler</i> ADDRESS <b>9015 CONKLING ST. BALTO., 24, MD.</b>		24a. REC'D BY REGISTRAR <b>JUL 19 61</b>	
		24b. REGISTRAR'S SIGNATURE <i>Christina S. Kraus</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7658

07649

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 35 A Silver Spring Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>A.</u> Last <u>Loeffler</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1885</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Herman Wuntz</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Albertina Turner</u> Address <u>Box 35 A Silver Spring Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart failure</u> DUE TO (b) <u>Terminal pneumonia</u> DUE TO (c) <u>Undiagnosed Pulmonary Infiltration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 19 19 61</u> to <u>July 10 19 61</u> that (I) (we) lost saw the deceased alive on <u>July 10 19 61</u> , and that death occurred on <u>July 11 19 61</u> at <u>1220 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Theodore E. Evans</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>7/11/61</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M.D.</u>				22d. ADDRESS <u>9660 Belair Road - 6 - Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		23d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lanham Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Clifford S. Evans</u>			

1947

CERTIFICATE OF DEATH

1947

(M)

STATE OF CALIFORNIA  
COUNTY OF LOS ANGELES

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Los Angeles, State of California.

Witness my hand and the seal of the County of Los Angeles, State of California, this \_\_\_\_\_ day of \_\_\_\_\_, 1947.

\_\_\_\_\_  
County Clerk

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7659

CERTIFICATE OF DEATH

07650

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>808 Chumleigh Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>101 Woodlawn Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Florence E. Losey</u> <b>4. SEX</b> <u>Female</u> <b>5. COLOR OR RACE</b> <u>White</u> <b>6. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>7. DATE OF BIRTH</b> <u>Aug. 9, 1894</u> <b>8. AGE</b> (In years last birthday) <u>66</u> yrs. <b>9. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>11</u> <b>10. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u> <b>13. FATHER'S NAME</b> <u>Frederick P. Todd</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Melle Stewart</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>yes</u> <b>17. INFORMANT</b> <u>Mrs. Robert R. Goll</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>BRONCHOPNEUMONIA</u> DUE TO <u>ATHELECTASIS</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>HYPERTENSION</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>20. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>July 11, 1961</u> Hour e.m. <u>19</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <u>Baltimore, Maryland</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 16, 1948</u> <b>to</b> <u>July 11, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>July 11, 1961</u> , <b>and that death occurred at</b> <u>5 AM</u> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Stuart D. Sunday</u> M.D. <b>22b. DATE SIGNED</b> <u>July 11, 1961</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>STUART D. SUNDAY</u> <b>22d. ADDRESS</b> <u>201 E. 35th St. - Baltimore (18) Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>July 14, 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Louisa Park Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Jul 12 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>William L. Thomas</u>	



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St. John's, N. B.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7660

07651

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>66 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4323 Barrington Road (29)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES SWAN LUTZ</b>		4. DATE OF DEATH Month Day Year <b>July 24 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1890</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Office</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Elisha H. Lutz</b>	
14. MOTHER'S MAIDEN NAME <b>Martha B. Roe</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes. WW I</b>	
16. SOCIAL SECURITY NO. <b>A-849657</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>POST RADIATION STATE CARCINOMA, URINARY BLADDER</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic Heart Disease - unknown duration. Benign Prostatic Hypertrophy - unknown duration. Chronic Pyelonephritis, duration - Unk.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he/she) (this hospital) attended the deceased from <b>May 18 1961</b> to <b>July 24 1961</b> that (he/she) saw the deceased alive on <b>July 24 1961</b> and that death occurred at <b>12:26 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Crahan</b> 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22b. DATE SIGNED <b>7/24/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/27/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Christian Church</b>	23d. LOCATION (City, town or county) (State) <b>Harford County, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons, Inc. North and Pennsylvania Aves., Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 26 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7661

07652

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY in 1b <u>months 7</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>7</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>909 Hollins</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theresa M. Marsiglia</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>9</u> Day <u>3</u> Year <u>1868</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9c. AGE (In years last birthday) <u>93</u> yrs.
10a. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		10b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. FATHER'S NAME <u>Unknown</u>		12. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. SOCIAL SECURITY NO. <u>Unknown</u>	
15. INFORMANT <u>Mrs. Fannie Barnabee</u>		Address <u>Same</u>	
16. CAUSE OF DEATH [Enter only one causa par linea for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombotic Heart</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Coronary Arteries</u> DUE TO <u>115.2 Mrs. B. Barnabee</u> (c) <u>115.2 Mrs. B. Barnabee</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>61</u> , to <u>7/31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u> M.D.		22b. DATE SIGNED <u>8/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>5805 EDWARDS AVE. BALTIMORE 28, MD.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town or county) (State) <u>4430 Belair Rd. Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son Inc. Hollins</u>		25a. REC'D BY REGISTRAR <u>Aug 3 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Hines</u>	

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James C. Thompson

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07653**

7662

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oliver Beach</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oliver Beach Baltimore, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 47, Greenbank Road</b>				d. STREET ADDRESS <b>719 N. Belnord Avenue 3/01-4</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>C.</b> Last <b>MATRAS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1909</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES MATRAS</b>				14. MOTHER'S MAIDEN NAME <b>KARLA KRAL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>Army WW2</b>		17. INFORMANT <b>Mother, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour <b>0</b> a. m. <b>19</b> p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/6/61</b>			
EXAMINER'S NAME (Type) <b>M. B. Davis MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/7/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bohemian National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b> <b>2601-3-5 E. Madison St.</b>				24a. REC'D BY REGISTRAR <b>JUL 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

NAME OF DECEASED  
M. J. [illegible]

AGE  
[illegible]

SEX  
[illegible]

DATE OF DEATH  
[illegible]

PLACE OF DEATH  
[illegible]

CAUSE OF DEATH  
[illegible]

MODE OF DEATH  
[illegible]

DATE OF EXAMINATION  
[illegible]

[Extremely faint and mostly illegible text, likely containing medical history and examination findings.]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07654

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> Bear Creek MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 5</u>	
c. LENGTH OF STAY IN 1b <u>rx</u>		d. STREET ADDRESS <u>2226 East Eager Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Troy</u> Middle <u>L.</u> Last <u>McCarty</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1944</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>16</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Levenson &amp; Klein</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Carl C. McCarty</u>	
14. MOTHER'S MAIDEN NAME <u>Etta Brantley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218-42-0388</u>		17. INFORMANT <u>Carl C. McCarty, 2226 East Eager Street</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Boat Drowning, accidental</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>929.8</u> DUE TO (c) <u>929.8</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Attempted to swim 100 yards from Bales Yacht Co. to Lynch Cove Marina pier</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7/4 19 61</u> Hour a. m. <u>7</u> p. m. <u>4</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bear Creek</u>		20f. (City or town) <u>Bear Creek</u> (County) <u>Balto</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C. Collins, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-6-61</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-8-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Towson 4, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>7 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION



07655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07655

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural- Towson</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
c. LENGTH OF STAY IN 1b <b>2 months</b>				d. STREET ADDRESS <b>631 Roland Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holly Hill Manor</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Agnes</b>		First <b>G.</b>		Middle <b>McComas</b>		Last	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9, 1871</b>	
9. AGE (In years at birthday) <b>90</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. DATE OF DEATH <b>July 24, 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Hollin Beaumont</b>			
14. MOTHER'S MAIDEN NAME <b>Mary J. Engle</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>----</b>				17. INFORMANT <b>E. Broadway</b> <b>Herbert L. McComas Bel Air, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO (b) <b>Arteriosclerotic Cardio-Renal</b> DUE TO (c) <b>Vascular Disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 28, 1961</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Presby. Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Jarrettsville, Harf. Co., Md.</b>			
23. FUNERAL DIRECTOR <b>Joseph W. Foster</b> <b>W. Broadway &amp; Williams St.</b> <b>Bel Air, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUL 27 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>				DATE <b>7/24/61</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7665

## CERTIFICATE OF DEATH

07656

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL (NMI) McCRAY</b>		4. DATE OF DEATH <b>JULY 8 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/13/11</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sugar Factory</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Camden, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie McCray</b>		14. MOTHER'S MAIDEN NAME <b>Mattie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>217-14-3656</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md.</b>		Address <b>Fort Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSION - MALIGNANT</b> DUE TO <b>445X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>HYPERTENSIVE ENCEPHALOPATHY</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 7, 1961</b> , to <b>July 8, 1961</b> that (1) (we) last saw the deceased alive on <b>July 8, 1961</b> , and that death occurred <b>4:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski</b> M.D.		22b. DATE SIGNED <b>7/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>		25a. REC'D BY REGISTRAR <b>JUL 19 '61</b>	
ADDRESS <b>1000 Brantley Avenue Baltimore 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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(M)

Mr. Jones

Bellevue

Bellevue

10 House

10 House

2447 N. Lawrence Avenue

Bellevue Administration Building

July 8, 1961

Dear Sir:

RE: (M)

is

SAVANNAH

Bellevue

Bellevue

U.S.A.

Bellevue, South Carolina

Bellevue, South Carolina

Bellevue

Bellevue

Bellevue

2447 N. Lawrence Avenue, Bellevue, South Carolina

Yes

1 year

Bellevue - Savannah

1 week

Bellevue - Savannah

July 8, 1961

July 8, 1961

Bellevue

Bellevue

Bellevue

Bellevue, South Carolina

Bellevue, South Carolina

Bellevue, South Carolina

Bellevue, South Carolina

Bellevue

July 8, 1961

1000 Broadway Avenue

Bellevue, South Carolina



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7666

07657

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucy Jane McCready</u>		4. DATE OF DEATH Month Day Year <u>7 23 19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>23</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Ford</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Edna Algire</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> DUE TO <u>multiple. Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Cerebral Vascular thrombosis</u> (c) <u>old hemiplegic left side</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old hemiplegic left side</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1956 7/23/61</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1956 7/21/61</u> to <u>1961 7/23/61</u> , that (I) <u>have</u> last saw the deceased alive on <u>7/21/61</u> , and that death occurred <u>7:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W.E. McGrath MD</u>		22b. DATE <u>7/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.E. McGrath MD</u>		22d. ADDRESS <u>1303 Frederick Rd (28)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 27 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07658

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Glenoe</u>		c. LENGTH OF STAY IN 1b <u>life</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glenoe - rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>STERRET</u> Last <u>McCulloch</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>15</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 1, 1861</u>
<b>9. AGE</b> (In years last birthday) <u>100</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>Henry H. Carroll</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Winchester</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> Address <u>Henson McCulloch above</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (the hospital) attended the deceased from <u>Jan 15</u> to <u>July 15</u>, 1961, that (I) (we) last saw the deceased alive on <u>July 14</u>, 1961, and that death occurred at <u>12:25 A</u> M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Elizabeth B. Shennill M.D.</u>		<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Elizabeth B. Shennill, M.D.</u>		<b>22d. ADDRESS</b> <u>Cockeysville, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7-15-61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Immanuel Epis</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Glenoe, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Brooks Funeral Service, Towson 4 Md</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>JUL 18 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1888

CERTIFICATE OF DEATH

1888



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7668

## CERTIFICATE OF DEATH

Reg. Dist. No.

07659

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>13 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3424 Sollers Point Road</b>			d. STREET ADDRESS <b>3424 Sollers Point Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>ALOYSUIS</b> Last <b>McGOVERN</b>			4. DATE OF DEATH Month <b>July</b> Day <b>2nd</b> Year <b>1961</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1876</b>	9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Michael McGovern</b>			14. MOTHER'S MAIDEN NAME <b>Rose Leonard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-14-4458</b>		17. INFORMANT <b>Mrs. Jeannette Mulhern same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>diabetes mellitus</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gangrene of both feet</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b> <b>December 1960</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <b>December, 1960</b> , to <b>July 2 - 1961</b> , that I last saw the deceased alive on <b>July 2nd, 1961</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>107 Main Street</b> DATE SIGNED <b>7/3/61</b>					
ACTUAL SIGNATURE <b>Joseph H. Thomas</b>		M.D. <b>107 Main Street</b>			
PHYSICIAN'S NAME (Type) <b>Joseph H. Thomas, M.D.</b>		<b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cmty.</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		ADDRESS _____		24a. REC'D BY REGISTRAR DATE <b>Jul 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		_____			

CERTIFICATE OF DEATH

7-6-62

11000

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH 1-1-1901		PLACE OF BIRTH BALTIMORE, MARYLAND	
SEX Male		RACE White		EDUCATION High School	
MARRIAGE Married		DATE OF MARRIAGE 1-15-1925		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
OCCUPATION Salesman		DATE OF DEATH 7-6-62		PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 11000	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESS John J. Harris		SIGNATURE OF PHYSICIAN Dr. J. H. Harris	
DATE 7-6-62		PLACE BALTIMORE, MARYLAND		COUNTY BALTIMORE	

(M)

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

07660

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>7 Weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bassett Home</u>		d. STREET ADDRESS <u>235 Blooming ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Franklin McGowan</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 3-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTH PLACE (State or foreign country) <u>Berkeley Springs Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William McGowan</u>		14. MOTHER'S MAIDEN NAME <u>Hovermale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-05-4632</u>	
17. INFORMANT <u>Mrs Margaret McGowan</u> Address <u>101 Dorchester</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Hypertensive Cardio-Vascular Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-20-1961</u> , to <u>7-12-1961</u> , that I last saw the deceased alive on <u>7-11-1961</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>7-13-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Berkeley Tree Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berkeley Spngs W Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward A Fink</u>		ADDRESS <u>Blue Bonnet Rd</u>	
24a. REC'D BY REGISTRAR <u>Jul 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	





13661

CERTIFICATE OF BIRTH

13661



CERTIFICATE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7671 CERTIFICATE OF DEATH 07662

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTO.</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b> c. LENGTH OF STAY IN 1b <b>36 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>406 OAK AVE.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b> d. STREET ADDRESS <b>406 OAK AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>CHRISTINA M. MOLZ</b>		<b>4. DATE OF DEATH</b> <b>JULY 16 1961</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>OCT. 24, 1881</b>
<b>9. AGE</b> (In years last birthday) <b>79</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>BALTO. CO. MD.</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>11. BIRTHPLACE</b> (County & State, or foreign country)		<b>14. MOTHER'S MAIDEN NAME</b> <b>SIBLE</b>	
<b>13. FATHER'S NAME</b> <b>CHRISTIAN SIBLE</b>		<b>17. INFORMANT</b> <b>WM. J. MOLZ SR.</b> Address <b>406 OAK AVE.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>153.2</b> DUE TO <b>OF DESCENDING COLON</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>8 Mo</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from 3/24/61 to 7/16/61, 1961, that (I) (we) last saw the deceased alive on 7/15/61, 1961, and that death occurred at 95A, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Joseph Miceli</b> M.D.		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOSEPH MICELI M.D.</b>		<b>22d. ADDRESS</b> <b>108 S. TAYLOR AVE BALTO. 21 MD.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7/20/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>OAK LAWN</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>BALTO. CO. MD.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>G.W. Hoffmann</b> ADDRESS <b>3218 HUDSON ST.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 18 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. House</b>	



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ST. AUGUSTINE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7672

07663

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>1mth8dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>109 North Carey Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Inez L. Montgomery</b>		4. DATE OF DEATH Month Day Year <b>July 30 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Lowella Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardiovascular disease</b> (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nodular cirrhosis of liver - Laennec's</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>June 20, 1961</b> to <b>July 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 30, 1961</b> , and that death occurred at <b>6:30 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Loretta Hsu</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu, M. D.</b>		22b. DATE SIGNED <b>7-31-61</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Maryland</b>		23a. REC'D BY REGISTRAR <b>AUG 2 '61</b>	
23b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETERS</b>	
23d. LOCATION (City, town or county) (State) <b>BALTO. MD.</b>		23e. DATE <b>AUG 2 '61</b>	
23f. REMOVAL (Specify) <b>BURIAL</b>		23g. DATE THEREOF <b>8/2/61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WITKE F.D.</b>		24b. ADDRESS <b>4101 EDMONDSON AVE</b>	

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WITTE F.D. WOLFENDONSON AOF  
BANK 2/21 AT PETERS  
BANK MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7673  
CERTIFICATE OF DEATH  
07664

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>184rs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1913 Halethorpe Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> X	
3. NAME OF DECEASED (Type or print) First <u>James L.</u> Middle <u>Moran</u> Last <u></u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Edith H. Moran</u>		Address <u>1913 Halethorpe Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chor Myocarditis</u> <u>527.1</u> DUE TO <u>decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Broncho pneumonia</u> <u>terminal</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 mo</u> <u>9 yrs</u> <u>90d.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1961</u> to <u>July 24, 1961</u> that (I) (we) last saw the deceased alive on <u>July 24, 1961</u> and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B B Brumbaugh</u>		22b. DATE SIGNED <u>7/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		22d. ADDRESS <u>5609 main st Elbridge 27 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amrose, Inc. 1328 Sulphur Spring Rd</u>		25a. REC'D BY REGISTRAR <u>JUL 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

(M)

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

07665

7674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2010 Gwynn Oak Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Morgenstern</u> Last <u>Sr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Morgenstern</u>		14. MOTHER'S MAIDEN NAME <u>Louise Beret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212.34.3982</u>	
17. INFORMANT <u>Emma Morgenstern</u>		Address <u>2010 Gwynn Oak Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 18</u> , 19 <u>59</u> , to <u>July 31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emidio A. Bianco</u>		ADDRESS (Street, city or town, state) <u>6322 Windsor Mill Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Emidio A. Bianco, M.D.</u>		DATE SIGNED <u>7/31/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/2/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

# CERTIFICATE OF DEATH

STATE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7675  
CERTIFICATE OF DEATH

07666

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY in 1b <b>5 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>522 East Coldspring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Theodore</b> Middle <b>W</b> Last <b>MORRIS</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>15</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-26-86</b>
<b>9. AGE</b> (In years last birthday) <b>74</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Yard Helper</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Burlington Iowa</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Louis Morris</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Augusta F Willer</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (If yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW-1</b>	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Clin Rec VAH Baltimore 18 Md-Ft Howard Div.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, LEFT LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>CHRONIC PYELONEPHRITIS - UNKNOWN DURATION</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 10, 1961</b> to <b>July 15, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 15, 1961</b> , and that death occurred at <b>3:00 a.m.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>John D. Talbert, M.D.</b> M.D.		<b>22b. DATE SIGNED</b> <b>7-15-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>John D. Talbert M.D.</b>		<b>22d. ADDRESS</b> <b>VAH Baltimore 18 Md-Ft Howard Division</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>7-16-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Henry W Jenkins &amp; Sons Co.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>4905 York Rd Baltimore 12 Md</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE Jul 18 '61</b>

05000

1073

(M)

Virginia

Alabama

Virginia

2 Type

East Ward

222 East Coldeking Lane

Veterans Administration Hospital

10000

Theodore

10000

White

Male

74

W.B.A.

Washington Town

Refused

Year before

James T. Miller

James Morris

Officer Van Belmont in West Ward Div.

Yes

UNKNOWN

SPRINGFIELD, EAST WARD

GENERAL INVESTIGATION - UNKNOWN INQUIRY

July 12 1961

July 12 1961

X

7-12-61

X

Van Belmont in West Ward Division

John D. Tabor M.N.

Baltimore Maryland

Baltimore National

7-12-61

Central

Henry W. Jenkins & Son Co. Baltimore Md

## CERTIFICATE OF DEATH

Reg. Dist. No. 07667

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manor Rd.</u>		d. STREET ADDRESS <u>1125 W. Franklin St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>P.</u> Last <u>Mueller</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Mooney</u>		14. MOTHER'S MAIDEN NAME <u>Ophelia Whitehair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-8679</u>	
17. INFORMANT <u>Walter S. Mueller</u>		Address <u>1125 W. Franklin St. 23</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1961</u> , to <u>July</u> , 1961, that I last saw the deceased alive on <u>July 27</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>7-27-61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-31-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 31 '61</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07668

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Timonium</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Timonium</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>209 Charmuth Road</i>		d. STREET ADDRESS <i>209 Charmuth Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Edward Adam Musch</i>		4. DATE OF DEATH Month <i>July</i> Day <i>10th</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 10, 1890</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. UNDER 1 YEAR Months <i>7</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman Warner - Fruehof</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gustav Musch</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Moser</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Anna M. Musch</i>		Address <i>209 Charmuth Road.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF PROSTATE AND BLADDER WITH</i> <i>199X</i> DUE TO <i>METASTASES TO BONY SKELETON</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>APRIL 1960</i> to <i>JULY 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>JULY 10, 1961</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Hugh M. Brown</i>		22b. DATE SIGNED <i>JULY 10 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>HUGH M. BROWN M.D.</i>		22d. ADDRESS <i>1103 ST. PAUL ST. BALTIMORE MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/12/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24b. ADDRESS <i>5305 Harford Road #14</i>	
25a. REC'D BY REGISTRAR <i>JUL 12 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

30350

(M)

(I)

Received of the Treasurer of the United States for the sum of \$100.00

for the purchase of 100 shares of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon

to the order of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon

to the order of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon

to the order of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon

to the order of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon

to the order of the United States Savings Bonds

at the rate of \$1.00 per share

and the interest thereon



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7678

07669

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>21 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>201 S. Bouldin Street</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JOHN</b> Middle <b>L.</b> Last <b>MYERS</b>				<b>4. DATE OF DEATH</b> Month <b>JULY</b> Day <b>24</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/10</b>	
9. AGE (in years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b>		IF UNDER 24 HRS. Hours <b>50</b> Min. <b>50</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Myers</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Chisholm</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>213-10-3082</b>			
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>162.1</b> (c) <b>162.1</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 WEEKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) (this hospital) attended the deceased from <b>7/3/1961</b> to <b>7/24/1961</b> , that (1) (we) last saw the deceased alive on <b>7/24/1961</b> and that death occurred at <b>5:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>M. Lawrence Reubin</b>				22b. DATE SIGNED <b>XX</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. LAWRENCE REUBIN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-27-61.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>				25a. REC'D BY REGISTRAR <b>JUL 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	
ADDRESS <b>901 S. Conkling St. Baltimore 24, Maryland</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

# CERTIFICATE OF DEATH

Reg. Dist. No. 07670

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>37 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3011 Willoughby Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD C. NESS SR</u>		4. DATE OF DEATH <u>July 18 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HORSE SHOE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>WESTERN MD DAIRY</u>	
13. FATHER'S NAME <u>GEORGE C. NESS</u>		14. MOTHER'S MAIDEN NAME <u>HESTER A CONSTANTINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS E. C. NESS SR</u>		Address <u>3011 Willoughby Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>Chronic Myocarditis</u> <u>Arteriosclerotic Cardiovascular disease</u> <u>Associated Bronchial asthma; pulmonary emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 18, 1942</u> to <u>July 18, 1961</u> , that I last saw the deceased alive on <u>July 17, 1961</u> , and that death occurred at <u>1:40 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.V. Harbold</u>		DATE SIGNED <u>July 19, 1961</u>	
PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u>		ADDRESS (Street, city or town, state) <u>Baltimore-14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-21-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Crane &amp; Son</u>		ADDRESS <u>8802 Hanford Rd</u>	
24a. REC'D BY REGISTRAR <u>JUL 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7680

07671

1. PLACE OF DEATH a. COUNTY <u>Baltimore, County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11600 Reistertown Rd.</u>		e. STREET ADDRESS <u>Owings Mills</u> <u>11600 Reistertown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>K.</u> Last <u>Niemeyer</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Baumann</u>		14. MOTHER'S MAIDEN NAME <u>Marie Weivking</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. W. L. Niemeyer</u>		Address <u>11600 Reistertown Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Heart Failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> 5 days 15 years		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 30</u> , 19 <u>47</u> to <u>July 28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 28</u> , 19 <u>61</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Walter Landau</u> M.D.		22b. DATE <u>7-29-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Walter Landau, M.D.</u>		22d. ADDRESS <u>Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 1, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tiekner + Sons, North &amp; Pa. o.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

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28. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7681  
CERTIFICATE OF DEATH  
07672

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 E. Elm Ave.</b>		d. STREET ADDRESS <b>29 E. Elm Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Augusta</b> Middle <b>A.</b> Last <b>Oberender</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1868</b>
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown Batz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Freda Oberender</b>		Address <b>29 E. Elm Ave. 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Cordis vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Under</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Under</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1956</b> Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>7-28</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7-22</b> 19 <b>61</b> , and that death occurred at <b>6</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Hyle</b>		22b. DATE SIGNED <b>7-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>		22d. ADDRESS <b>7527 Belair Rd Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-31-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 31 '61</b>	
ADDRESS <b>7401 Belair Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	



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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7682

07673

4. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>3yr11mth3dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		5. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Arbutus</b> d. STREET ADDRESS <b>1423 Stevens Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED <b>Anna Johanna Oelzner</b> (Type or print) <b>Anna Johanna Oelzner</b>		4. DATE OF DEATH <b>July 22 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1879</b>
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick Strasser</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gartner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> (c) <b>Occlusus ulceras.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 10 1961</b> , to <b>July 22 1961</b> , that (I) (we) last saw the deceased alive on <b>July 22 1961</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H.I. Cholmondeley</b> M.D.		22b. DATE SIGNED <b>7/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.I. Cholmondeley</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/25/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Anne Arundel County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave.</b>		25a. REC'D BY REGISTRAR <b>JUL 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanks</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7683

CERTIFICATE OF DEATH

07674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>3316 PARK LAWN AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>KATHERYN</u> Last <u>ORTMAN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-02</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>19</u> Min. <u>19</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11c. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENNIS HANLIN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH F. ORTMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>002 X</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002 X</u> (c) <u>RHEUMATOID ARTHRITIS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
21. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>5-11-1961</u>		22. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD</u>		24. (City or town) (County) (State) <u>BALTIMORE</u>	
25. I certify that (I) (this hospital) attended the deceased from <u>5-11-1961</u> to <u>7-9-1961</u> that (I) (we) last saw the deceased alive on <u>7-9-1961</u> , and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above.		26. SIGNATURE <u>Wm. Newcomer, M. D. Superintendent</u>	
27. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M. D. Superintendent</u>		28. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>	
29. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		30. DATE THEREOF <u>7/12/61</u>	
31. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		32. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
33. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck - 5305 Harford Rd.</u>		34. REC'D BY REGISTRAR DATE <u>JUL 11 '61</u>	
35. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		36. DATE <u>JUL 11 '61</u>	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/83 BY SP-6 JLM/STW



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7684

CERTIFICATE OF DEATH

Item 23b, Film G290 7/13/61 iwk

07675

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (15)</b> d. STREET ADDRESS <b>5219 Linden Heights Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CIARENCE M. OTT</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>August 2, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lee Ott</b>		14. MOTHER'S MAIDEN NAME <b>Helen Manning</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-10-8890</b>	
17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>502 ✓</b> (b) <b>CHRONIC BRONCHITIS</b> DUE TO (c) <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastroduodenitis with hemorrhage. Pulmonary emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 26, 1961</b> , to <b>July 5, 1961</b> that (X) (we) last saw the deceased alive on <b>July 5, 1961</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Craham</b> M.D.		22b. DATE SIGNED <b>7/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Craham</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 8, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons, Inc., North &amp; Penna. Aves.</b>		25a. REC'D BY REGISTRAR <b>JUL 10 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>		25c. DATE	

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Mr. J. Thompson & Sons, Inc., Boston, Mass.

United States Department of Justice

Mr. J. Thompson & Sons, Inc., Boston, Mass.

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
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7685

# CERTIFICATE OF DEATH

Reg. Dist. No. 07676

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3609 Forest Hill Road</b>		e. STREET ADDRESS <b>3609 Forest Hill Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Ferree</b> Last <b>Pennock</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Pennock</b>		14. MOTHER'S MAIDEN NAME <b>Levina Chamberlian</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-0157</b>	
17. INFORMANT <b>Adelaide L. Cashmyer-3609 Forest Hill Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ex. Card Vase Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Generalized Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-10</b> , 19 <b>55</b> , to <b>7-14</b> , 19 <b>61</b> , that I lost the deceased alive on <b>7-14</b> , 19 <b>61</b> , and that death occurred at <b>7:15</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. John J. Arbo</b>		ADDRESS (Street, city or town, state) <b>4509 Liberty Hwy. Baltimore</b>	
DATE SIGNED <b>7-15-61</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights Ave.</b>	
24a. REC'D BY REGISTRAR <b>JUL 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Huns</b>	

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CERTIFICATE OF DEATH

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*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

*[Vertical text along the right margin, likely from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7685

## CERTIFICATE OF DEATH

07677

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3821 Patterson Avenue</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3821 Patterson Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>J. Joseph Pentz</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>July 5 19 61</b> Month Day Year	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 30, 1892</b> Month Day Year
<b>9. AGE</b> (In years last birthday) <b>68 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>American Smelting &amp; Refining Baltimore, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>John Joseph Pentz Sr.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Eleanor ?</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Mrs. Ruth A. Pentz</b>	
<b>17. INFORMANT</b> <b>3821 Patterson Ave. 7</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>12 years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) *****	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>*****</b> p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>*****</b>	<b>20f. (City or town)</b> (County) (State) <b>*****</b>
<b>21. I certify that (I) (this hospital) attended the deceased from..... 19 49 to July....., 19 61 that (I) *last saw the deceased alive on..... July 4, 19 61, and that death occurred at 11:15 AM from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Millard T. Traband, Jr. M. D.</b>		<b>22b. DATE SIGNED</b> <b>7 July 1961</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Millard T. Traband, Jr. M. D.</b>		<b>22d. ADDRESS</b> <b>5101 Gwynn Oak Ave. Baltimore, 7, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>July 8, 61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park Cemetery</b>	<b>23d. LOCATION (City, town or county)</b> (State) <b>Woodlawn, Maryland</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. J. Zuckner - Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUL 10 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hantz</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7687

## CERTIFICATE OF DEATH

Reg. Dist. No. 07678

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived). If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>529 Park Ave</u>				d. STREET ADDRESS <u>529 Park Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Elizabeth</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 December 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balt. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Brand Pindell</u>				14. MOTHER'S MAIDEN NAME <u>Emily Folger Buck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Husband - Carlitos</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>12 yrs</u> <u>20 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1960</u> to <u>July 1961</u> , that I last saw the deceased alive on <u>28 July 1961</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.				ADDRESS (Street, city or town, state) <u>Cockeysville Maryland</u> DATE SIGNED <u>28 July 1961</u>			
PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DEWID RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. COOK-TOWSON</u>				ADDRESS <u>1050 YORK RD</u>		24a. RECEIVED BY REGISTRAR <u>—</u> DATE <u>—</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07679

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> 19 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto - 19</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>		c. LENGTH OF STAY IN 1b <i>7 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>R 10. Box 308 A</i>		d. STREET ADDRESS <i>2133 Lincoln Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ROSA Etta PHILLIPS</i>		4. DATE OF DEATH Month Day Year <i>July 10 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 15, 1883</i>
9. AGE (In years last birthday) <i>77</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>iron home</i>	
11. BIRTHPLACE (State or foreign country) <i>Richmond, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>George Gifford</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ellen Martin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Ed. Phillips</i>		Address <i>address as in # 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma Uterus</i> DUE TO <i>174X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>with secondary anemia</i> DUE TO <i>2 months</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb</i> 19 <i>31</i> to <i>July 10</i> 19 <i>61</i> , that I last saw the deceased alive on <i>June 22</i> 19 <i>61</i> and that death occurred at <i>9:20 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Tollin</i>		DATE SIGNED <i>7/10/61</i>	
PHYSICIAN'S NAME (Type) <i>Louis N. Tollin</i>		ADDRESS (Street, city or town, state) <i>6908 N. POINT RD BALTIMORE - M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/13/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley, Inc., Dundalk 22</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 13 61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07680

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>559 Sue Grove Rd.</u>		d. STREET ADDRESS <u>559 Sue Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHAS</u> Middle <u>Ernest</u> Last <u>Pierce</u>		4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8 - 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>65</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
12. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Meritt Price</u>		15. MOTHER'S MAIDEN NAME <u>Z.</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		17. SOCIAL SECURITY NO. <u>WWI</u>	
18. INFORMANT <u>Geo Brown</u>		19. Address <u>241 Redwood Dr. Lancaster Pa.</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>974X</u> (a), stating the underlying cause last. DUE TO (c) <u>974X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>974X</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Hour <u>0</u> o. m. <u>19</u> p. m.		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23b. (City or town) (County) (State)	
24. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-27-61</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25b. DATE THEREOF <u>7/29/61</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem</u>		25d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Rolph Reed</u>		ADDRESS <u>Rising Sun</u>	
27a. REC'D BY REGISTRAR <u>DATE 31 '61</u>		27b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7690

07681

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3344 Ripple Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>POLINSKY</b> Last <b>POLINSKY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1914</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scrap</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Polinsky</b>		14. MOTHER'S MAIDEN NAME <b>Viola ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>102-07-3149</b>	
17. INFORMANT <b>Mrs. Sylvia Polinsky- 3344 Ripple Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>ASHD, previous myocardial infarction</b> DUE TO (c) <b>3 1/2 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> to <b>July 19 1961</b> , that (I) (we) last saw the deceased alive on <b>July 19 1961</b> , and that death occurred at <b>3 1/2</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Daniel Bakal</b>		22b. DATE SIGNED <b>July 19 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Daniel Bakal</b>		22d. ADDRESS <b>Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 20/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Aitz Chaim Anshe Emunah</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

MEDICAL CERTIFICATION

01081

CERTIFICATE OF DEATH

1900

M

7691

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

07682

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>211 Clarendon Ave., Pikesville</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elmer James Preble</b>				4. DATE OF DEATH Month Day Year <b>July 21, 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1910</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Baltio. Co. Fire</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elmer T. Preble</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Halligan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-0639</b>		17. INFORMANT <b>Mrs. Gladys Preble, 211 Clarendon Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>3 yrs</b> <b>&gt; 20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypercholesterolemia and obesity</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>August 1958</b> to <b>July 21, 1961</b> , that (I) <b>(me)</b> last saw the deceased alive on <b>7-19-1961</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>George M. Ramaputnam MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/24/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George M. Ramaputnam MD</b>				22d. ADDRESS <b>3502 Gaydon Rd Baltimore 2124</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Hendrick</b>				25a. REC'D BY REGISTRAR <b>AUG 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

07882

RECEIVED

1937

(M)

Hypercholesterolemia and obesity  
Hypertension  
Atherosclerotic Heart Disease  
Acute Myocardial Infarction

25013  
25012

Project 22, Study 21 of  
George W. Ransberger, M.D.  
3205 University Ave.  
Berkeley, Calif.  
1937

2-19-61  
George W. Ransberger, M.D.

March 24, 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
7692					07683				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY in 1b <b>3 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			d. STREET ADDRESS <b>21 West Preston Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>D.</b> Last <b>PRITCHARD</b>					4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 61</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11-24-96</b>		9. AGE (In years last birthday) <b>64</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cannery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Calvert Pritchard</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Heckman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>Yes WW-1</b>					16. SOCIAL SECURITY NO. <b>WW-1</b>				
17. INFORMANT <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CHRONIC BRAIN SYNDROME</b> DUE TO (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>								INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 12 1961</b> to <b>July 15 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 15 1961</b> , and that death occurred at <b>7:05 p.m.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Daniel R. Zoll</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7-16-61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Daniel R. Zoll</b> M.D.					22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight</b>					25a. REC'D BY REGISTRAR <b>JUL 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinne</b>		

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3 July

21 West Preston Street

Veteran Administration Hospital

ATTACHED

D.

JAMES

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White

Male

Baltimore, Maryland

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Laborer

Elizabeth Hoffman

Colvert Hoffman

Class No. 144 Baltimore 14 - 10 Bureau Division

HW-1

Yes

7 DATE

RECORDED

NUMBER

COMMUNIST MAIN SYNDICATE

INTERVIEWER: INVESTIGATING COMMUNIST MAIN SYNDICATE

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7693

07684

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Ma.</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>—</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Home, 1001 N. Rolling Rd</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <b>836 Glen Allen Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie G.</b> Middle <b>Redman</b> Last <b>—</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6/61</b> Year <b>19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 15/72</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Marion Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca---</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>Mrs. Paul Gaa, 836 Glen Allen Drive</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia Rt Base</b> DUE TO <b>1450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Age &amp; Being Bed fast</b> DUE TO <b>Arterio sclerosis gen</b> (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Diabetes ② Ca 7 btt Breast for advanced</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> 1959, to <b>July 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>7/6</b> 1961, and that death occurred at <b>—</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Cliff Ratliff</b>				22b. DATE SIGNED <b>7/7/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>				22d. ADDRESS <b>4605 Edmondson Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 8/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
23d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave. Balto. 29, Md</b>				25a. REC'D BY REGISTRAR <b>JUL 10 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7694

07685

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 Hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>		d. STREET ADDRESS <b>2611 Washington Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret E. Reichert</b> First Middle Last		4. DATE OF DEATH <b>July 28, 1961</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman Helwig</b>		14. MOTHER'S MAIDEN NAME <b>Anna Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clara Daehnke 2611 Washington Blvd.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast with wide- spread metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>170X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1959</b> , to <b>July 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 19, 1961</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Arthur Rossberg</b> M.D.		22b. DATE SIGNED <b>7/29/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Arthur Rossberg</b>		22d. ADDRESS <b>2436 Washington Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/31/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>AUG 1 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

1222

STATE OF TEXAS

1904

(M)

Case No. 1000

vs.

State of Texas

County of Dallas

City of Dallas

Plaintiff

Defendant

(1)

Wife

vs.

State of Texas

House No. 1000

Can. No. 1000

Wife

Wife

Wife

State of Texas

No.

State of Texas

State of Texas

State of Texas

State of Texas

State of Texas

State of Texas

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State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07686									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY in 1b <b>3yr5mth26dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>927 Washington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Inez Loretta Rhodes</b>					4. DATE OF DEATH <b>July 23/61</b> Month <b>July</b> Day <b>23</b> Year <b>1961</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Edward Howard</b>					14. MOTHER'S MAIDEN NAME <b>Bertie Martin</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia of left Lung</b> DUE TO <b>4443 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1958</b> to <b>July 23, 1961</b> that (I) (we) last saw the deceased alive on <b>9:00 AM July 19, 1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Inez KOPITS</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Inez KOPITS, M.D. (K-7077)</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b> ADDRESS					25a. REC'D BY REGISTRAR <b>JUL 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		

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July 23/51

St. Louis

7/27/51

St. Louis

St. Louis 10/10/51



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7696

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07687

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jones Creek</b>		c. LENGTH OF STAY IN 1b <b>15 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jones Creek</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 7302 Bay Front Road</b>			d. STREET ADDRESS <b>7302 Bay Front Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>James</b> Last <b>RIGLING</b>			4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>61</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1910</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Dept. Arcrods Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Rigling</b>			14. MOTHER'S MAIDEN NAME <b>Isabelle Forrest</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-4193</b>		17. INFORMANT Address <b>Mrs. Idabelle Grammer 114 Delight Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>JACK COLLINS</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7-17-61</b>	
EXAMINER'S NAME (Type) <b>JACK COLLINS, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-20-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	22d. LOCATION (City, town, or county) <b>Eastern Ave. Md.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA 7922 Wise Ave. 22, Maryland</b>			24a. REC'D BY REGISTRAR <b>JUL 20 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G292 8/4/61 iwk

Reg. Dist. No. 07688

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6526 Woodbridge Circle</u>								d. STREET ADDRESS <u>4212 Reisterstown Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Otie Florence Riley</u>				First		Middle		Last		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1898</u> <u>June 24, 1914</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George McCauley</u>								14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Walter E. Riley</u> Address <u>4212 Reisterstown Ave</u> <u>Barbara Bratkowski</u> <u>6526 Woodbridge Circle</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>												INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>											
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>July 29, 1961</u>							
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1010 Leeds Ave (29)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's, Hampden</u>				22d. LOCATION (City, town, or county) (State) <u>3900 Roland Ave, Baltimore Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>								ADDRESS <u>3818 Roland Ave</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698

CERTIFICATE OF DEATH

Reg. Dist. No. 07689

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>—</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House of the Pines</b>		d. STREET ADDRESS <b>1602 Cliftview Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edith V Rollison</b>		4. DATE OF DEATH Month Day Year <b>July 5 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 28 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Rock Hall Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>—</b>	
13. FATHER'S NAME <b>Daniel W Gilbert</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Samuel H. Rollison</b>		Address <b>1602 Cliftview Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Liver</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-1-</b> , 19 <b>61</b> , to <b>7-5-</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>2-3-</b> , 19 <b>61</b> , and that death occurred at <b>4:55 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Baltimore - 28, Md.</b>	
DATE SIGNED <b>7/6/61</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Amato</b>		ADDRESS <b>4204 Ridgewood Ave</b>	
24a. REC'D BY REGISTRAR <b>—</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	
DATE <b>Jul 7 '61</b>			

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

1. PLACE OF DEATH A. HOME		2. SEX MALE		3. AGE 100	
4. DATE OF DEATH JAN 10 1918		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. NAME OF DECEASED JOHN J. BROWN		8. OCCUPATION FARMER		9. MARITAL STATUS MARRIED	
10. CAUSE OF DEATH HEART DISEASE		11. MEDICAL HISTORY None		12. PREVIOUS ILLNESS None	
13. SIGNATURE OF PHYSICIAN J. B. BROWN		14. SIGNATURE OF WITNESS J. B. BROWN		15. SIGNATURE OF DECEASED None	
16. SIGNATURE OF COUNTY CLERK J. B. BROWN		17. SIGNATURE OF STATE CLERK J. B. BROWN		18. SIGNATURE OF DECEASED None	

M

RECEIVED  
JAN 10 1918  
BALTIMORE



7699

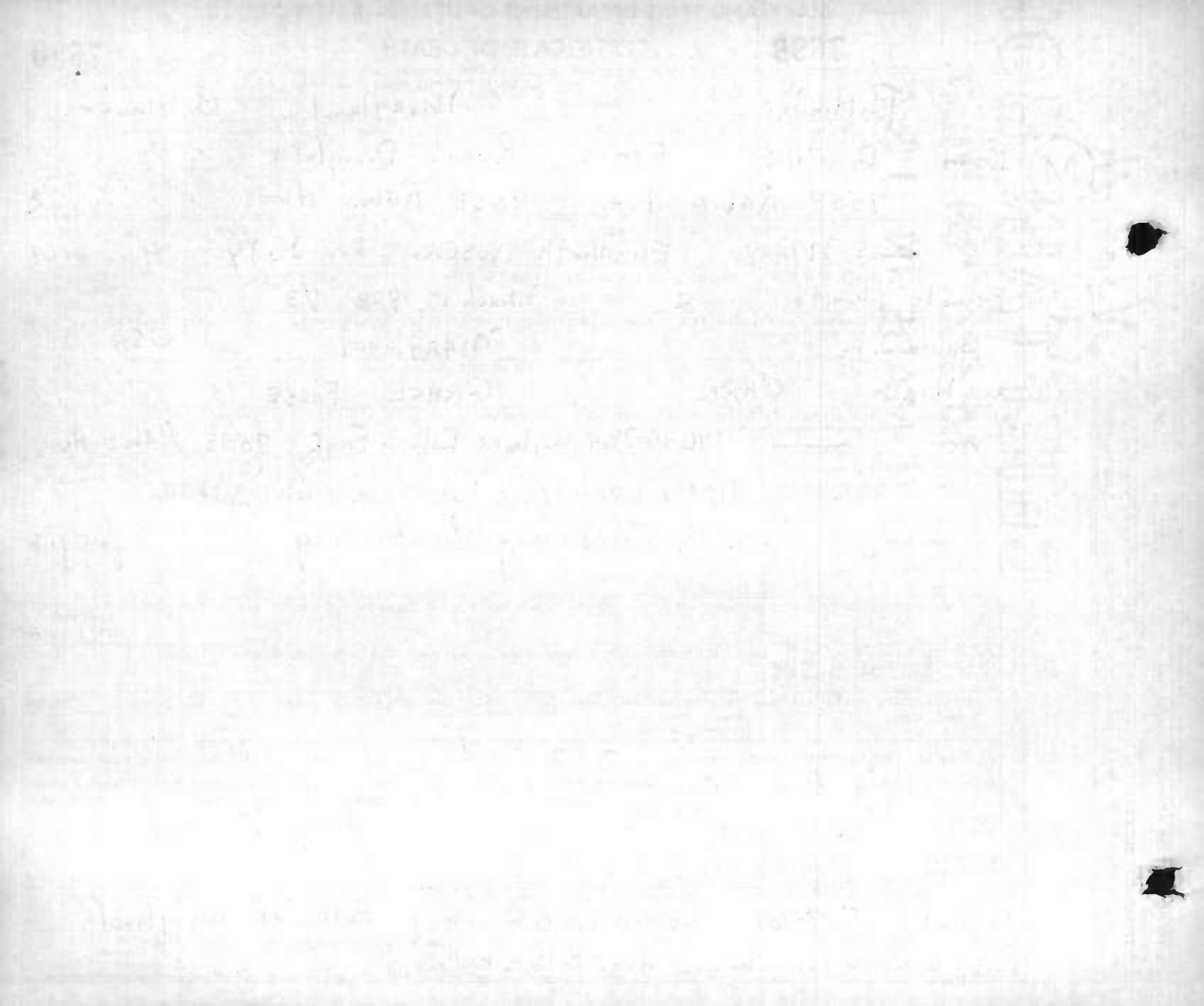
## CERTIFICATE OF DEATH

Reg. Dist. No. 07690

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Dundalk</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7558 Rabon Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE MARY</u> First <u>Elizabeth</u> Middle <u>ROSER.</u> Last		4. DATE OF DEATH <u>July</u> Month <u>4</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William CARR</u>		14. MOTHER'S MAIDEN NAME <u>GRACE FOOSE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>196-16-7964</u>	
17. INFORMANT <u>Wilmer Edwin Frye</u>		Address <u>7558 Rabon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with Coronary Insufficiency</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>a few yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-21-1961</u> to <u>7-4-1961</u> , that I last saw the deceased alive on <u>July 4, 1961</u> , and that death occurred at <u>5:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hea Rean LEW</u>		M.D. <u>July 5, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Hea Rean LEW</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-7-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cuch</u>		ADDRESS <u>1211 Chesaco Ave. Balto.-6 Md</u>	
24a. REC'D BY REGISTRAR <u>JUL 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7700

07691

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY in lb <b>since 7/25/61</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home in The Pines</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis Derr Russell</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>October-2-1866</b>
9. AGE (In years last birthday) <b>94 yrs.</b>		IF UNDER 1 YEAR Months <b>94</b> Days <b>27</b> Hours <b>15</b> Min. <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George W. Russell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wain</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>498-18-9996A</b>	
17. INFORMANT <b>Edw. L. Russell (son)</b>		Address <b>3640 Coolidge Av, Balti 29</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial Decomposition</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Generalized Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>15 yr</b> <b>20 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-12-1953</b> to <b>7-27-1961</b> , that (I) (we) last saw the deceased alive on <b>7-26-1961</b> , and that death occurred at <b>245 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilmer K. Gallagher</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, M.D.</b>		22d. ADDRESS <b>6209 Frederick Ave, Baltimore-28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>July 31 - 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore City (23)</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart &amp; Mowen Co., 108-W-North-Balto. 1.</b>		25. REC'D BY REGISTRAR <b>JUL 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

07681

0057

(M)

(I)

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Bureau" and "Department" are faintly visible.

Handwritten text at the bottom of the page, including what appears to be a signature and some administrative markings.

TO DULY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07692

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 24 Md.</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7034 Eastern Blvd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 24</u> d. STREET ADDRESS <u>17054 Eastern Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>August Conrad Schirmer</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-06</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> Hours <u>1</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Balto.</u>	
13. FATHER'S NAME <u>August Schirmer</u>		14. MOTHER'S MAIDEN NAME <u>Halburg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-01-9235</u>	
17. INFORMANT <u>Wife</u> (Same as above.)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-22-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 Eastern Blvd</u>	
24a. REC'D BY REGISTRAR <u>JUL 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

KANSAS STATE DEPARTMENT OF HEALTH - BATHING 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. BROWN  
 SEX: MALE AGE: 45 YEARS  
 DATE OF DEATH: 1918

PLACE OF DEATH: HOME  
 CAUSE OF DEATH: HEART DISEASE  
 DISEASE OR INJURY: HEART DISEASE  
 MANNER OF DEATH: NATURAL

SIGNATURE OF EXAMINER: [Signature]  
 OFFICE OF EXAMINER: [Signature]  
 COUNTY: JOHNSON

I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above is a true and correct statement of the facts in the case of the deceased, and that the same was examined and found correct by me.

WITNESSED my hand and seal of office this 19 day of August, 1918.

MEDICAL EXAMINER



1918 AUG 19 AM 10:30  
 1918 AUG 19 AM 10:30

1918 AUG 19 AM 10:30  
 1918 AUG 19 AM 10:30



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7702  
CERTIFICATE OF DEATH

07693

1. PLACE OF DEATH e. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN lb <i>X</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3305 Woodside Avenue</i>		d. STREET ADDRESS <i>3305 Woodside Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. William Schmuck</i>		4. DATE OF DEATH Month <i>July</i> Day <i>25th</i> Year <i>1961</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 25, 1886</i>
9. AGE (in years last birthday) <i>74 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Clerk</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Schmuck</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Hahn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give year or dates of service)</i>		16. SOCIAL SECURITY NO. <i>215-03-7384</i>	
17. INFORMANT <i>Mrs. Dorothy L. Tallton</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic CVD</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>II</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1951</i> to <i>7/25/61</i> , that (I) (we) last saw the deceased alive on <i>7/22/61</i> , and that death occurred at <i>8:00</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>H. A. Grott</i>		22b. DATE SIGNED <i>7/25/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. A. GROTT, M.D.</i>		22d. ADDRESS <i>8100 Harford Rd.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-28-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR <i>JUL 27 '61</i>	
ADDRESS <i>5305 Harford Road #14</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Plana</i>	

00170

3017



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

7703

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07694

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home</b>		d. STREET ADDRESS <b>4203 Wilkens Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>May</b> Last <b>Seifert</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1883</b>
9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Stahl</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT (daughter) <b>Flora M. Koellner</b>		Address <b>820 W. Fairview Ave. Hgts., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Dis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1942</b> to <b>July 29 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>July 29 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl Pass M.D.</b>		22b. DATE SIGNED <b>7-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl Pass, M. D.</b>		22d. ADDRESS <b>4001 Wilkens Avenue Baltimore 29, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue #29</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. L. Hume</b>	

2703

CERTIFICATE OF DEATH

(M)

(1)

Charles H. ...  
...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
090  
7704  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07695

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>		d. STREET ADDRESS <b>3404 W/ North Ave.</b> <b>3V01-4</b>	
3. NAME OF DECEASED (Type or print) <b>Helen R. Sexton</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Capt. Gregory Mullan</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>N. G. Sexton III Relay, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lower end of esophagus</b> 150 X DUE TO (b) <b>Metastasis to heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Myocardial infarction</b> (c) <b>Malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>3 mo</b> <b>1 mo</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1879</b> to <b>July 29, 1961</b> , that (I) <b>last</b> saw the deceased alive on <b>July 29, 1961</b> , and that death occurred at <b>4:15</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>B B Brumbaugh</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>		22d. ADDRESS <b>4609 Main St, Elbridge, Md</b>	
22b. DATE SIGNED <b>7/30/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>July 31, 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc. 1217 St. Paul St.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>			

M

Religion  
None

Married  
None

Address in the United States

John A. Nelson  
July 20

Place of birth  
Jan. 4, 1872

Education  
None

Current employment  
None

No. 10  
F. O. Nelson III, Holmdel, N.J.

Commission 1917-1921, 1921-1925, 1925-1929

at Cook Inc. 1917-1921, 1921-1925



7705

## CERTIFICATE OF DEATH

Reg. Dist. No. 07696

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>601 Orkney Rd.</i> c. COUNTY <i>12</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Aged Women &amp; Aged Men Home</i>				d. STREET ADDRESS <i>601 Orkney Rd.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MRS ROSE SHAW</i>				4. DATE OF DEATH Month Day Year <i>July 6- 1961</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13-1873</i>	9. AGE (In years lost birthday) <i>87</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i>		12. CITIZEN OF WHAT COUNTRY? <i>YES-USA</i>	
13. FATHER'S NAME <i>HERMAN BANKER</i>				14. MOTHER'S MAIDEN NAME <i>Does not know</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		INFORMANT Address <i>Kathleen Young - 615 Chestnut Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Bladder</i> <i>181.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>7 mos</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerosis Cerebral Vascular Disease</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January, 1960</i> , to <i>July 6th</i> , 1961, that I last saw the deceased alive on <i>July 5</i> , 1961, and that death occurred at <i>4:00 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4-E-33rd St Balto 18 Md.</i> DATE SIGNED							
ACTUAL SIGNATURE <i>Newland Edward Day</i> M.D.		DATE SIGNED <i>4-E-33rd St Balto 18 Md.</i>					
PHYSICIAN'S NAME (Type) <i>Newland Edward Day, M. D.</i>		ADDRESS <i>4 East 33rd st. Balto. 18, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/8/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i> ADDRESS <i>4107 Wilkens Ave. #29</i>				24a. REC'D BY REGISTRAR <i>JUL 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HO... AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-1-30

CENTRAL AIR OF DEATH

2002

(M)

1st Avenue, No.  
101 Ordway Rd.

Wishes

(I)

none

no

Continued later

Continued later

429

61

July 2

Wendell Everett Day

4 2-32-27

Howard Street, D. C.

1911

Howard, N. Hubbard 4107 Lincoln Ave.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7706

Name *Farm # 6292 81161 P.B.*

Reg. Dist. No. 07697

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodmor Section, Woodlawn</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodmor Section, Woodlawn</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3207 Fairview Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Norris</u> Middle <u>Russell</u> Last <u>Shea</u> Sr.			4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1919</u>		9. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Roadway Service Inc</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Charles Shea</u>		
14. MOTHER'S MAIDEN NAME <u>Luravena Poole</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.2</u>		
16. SOCIAL SECURITY NO. <u>W.W.2</u>			17. INFORMANT <u>Doris Shea</u> Address <u>3207 Fairview Ave</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot wound in rightside of head region of temple</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Revolver, self inflicted. Hole in head about size of allowing you to pass your small finger through wound.</u> (c) <u>Profuse bleeding</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself in right side of his head in region of temple right side</u>
20c. TIME OF INJURY Hour <u>7-30</u> a.m. <u>7-26</u> p.m. Month, Day, Year <u>7-26-61</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Woodlawn Baltimore Co. Md</u>

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ (inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>Geo. S.M. Kieffer M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>July 26, 1961</u>
EXAMINER'S NAME (Type) <u>Geo. S.M. Kieffer M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1010 Leeds Ave. 2</u>	

22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/29/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>OLD FREDERICK RD. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Sonnan</u>		24a. REC'D BY REGISTRAR <u>Jul 31 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07700

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>109 Days</b>		d. STREET ADDRESS <b>815 North Collington Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLINTON C. SNYDER</b>		4. DATE OF DEATH <b>July 22 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 28, 1886</b> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lathe Operator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Westminster, Maryland</b>	
13. FATHER'S NAME <b>Noah Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Mary Crumrine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war and dates of service) <b>WW-1</b>		17. INFORMANT <b>Clin Rec VAH Baltimore Md Ft Howard Division</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <del>XXXXX</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>BRAIN TUMOR RIGHT PARIETAL LOBE</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abscesses of lung and spleen; Coronary Arteriosclerosis; Cholelithiasis; marked.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 4, 1961</b> to <b>July 22, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 22, 1961</b> , and that death occurred at <b>12:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick S. Donaldson</b> M.D.		22b. DATE SIGNED <b>7-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick S. Donaldson</b> M.D.		22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-26-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cvach Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUL 26 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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Figure 9



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7710 CERTIFICATE OF DEATH 07701

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Md. Reisterstown Road, Owings Mills</b>				d. STREET ADDRESS <b>Reisterstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Keith Crawford Spayde</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1894</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Humboldt, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contracting Manger</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Humboldt, Iowa</b>	
13. FATHER'S NAME <b>James M. Spayde</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Deming</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.11</b>				16. SOCIAL SECURITY NO. <b>212-07-4472</b>			
17. INFORMANT <b>Mrs. Cora Stewart Spayde</b>				Address <b>Owings Mills, Md Reisterstown Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b> <b>15 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1958</b> to <b>July 1961</b> , that (I) (we) last saw the deceased alive on <b>July 6 1961</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Martin A. Feldman MD</b>				22b. DATE SIGNED <b>July 7 1961</b>		22c. ADDRESS <b>Cherry Hill Rd Reisterstown, Md</b>	
22d. PHYSICIAN'S NAME (Type) <b>Martin A. Feldman MD</b>				22e. ADDRESS <b>Cherry Hill Rd Reisterstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>				25a. REC'D BY REGISTRAR <b>Arthur L. Hume</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

3152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7711

CERTIFICATE OF DEATH

Reg. Dist. No. 07702

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res., 6617 Windsor Mill Rd.</b>		d. STREET ADDRESS <b>6617 Windsor Mill Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>JOSEPH</b> Middle <b>STACHURA</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1908</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Foster Bros. Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Stachura</b>		14. MOTHER'S MAIDEN NAME <b>Anna Slaga</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-1343</b>	
17. INFORMANT <b>Mrs. Helen Stachura</b>		Address <b>6617 Windsor Mill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERAL CACINOMATOSIS</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF PANCREAS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARDIAC FAILURE AND PULMONARY EDEMA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Mos</b> <b>6 Mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 25, 1961</b> , to <b>JULY 1, 1961</b> , that I last saw the deceased alive on <b>JULY 1, 1961</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Albert R. Wilkerson</b> M.D. <b>1200 ST. PAUL ST. BALTO-2, MD</b> PHYSICIAN'S NAME (Type) <b>Albert R. Wilkerson, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 5, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>		24a. REC'D BY REGISTRAR <b>JUL 7 '61</b>	
ADDRESS <b>2829 Hudson St. 24, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. MONTH	
7. CITY OF BIRTH		8. COUNTY OF BIRTH		9. STATE OF BIRTH	
10. OCCUPATION		11. MARITAL STATUS		12. CAUSE OF DEATH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE		21. SIGNATURE OF SHERIFF	
22. SIGNATURE OF CORONER		23. SIGNATURE OF JURY		24. SIGNATURE OF COURT	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF CORONER	
28. SIGNATURE OF JURY		29. SIGNATURE OF COURT		30. SIGNATURE OF JUDGE	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF CORONER		33. SIGNATURE OF JURY	
34. SIGNATURE OF COURT		35. SIGNATURE OF JUDGE		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF CORONER		38. SIGNATURE OF JURY		39. SIGNATURE OF COURT	
40. SIGNATURE OF JUDGE		41. SIGNATURE OF SHERIFF		42. SIGNATURE OF CORONER	
43. SIGNATURE OF JURY		44. SIGNATURE OF COURT		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF SHERIFF		47. SIGNATURE OF CORONER		48. SIGNATURE OF JURY	
49. SIGNATURE OF COURT		50. SIGNATURE OF JUDGE		51. SIGNATURE OF SHERIFF	
52. SIGNATURE OF CORONER		53. SIGNATURE OF JURY		54. SIGNATURE OF COURT	
55. SIGNATURE OF JUDGE		56. SIGNATURE OF SHERIFF		57. SIGNATURE OF CORONER	
58. SIGNATURE OF JURY		59. SIGNATURE OF COURT		60. SIGNATURE OF JUDGE	
61. SIGNATURE OF SHERIFF		62. SIGNATURE OF CORONER		63. SIGNATURE OF JURY	
64. SIGNATURE OF COURT		65. SIGNATURE OF JUDGE		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF CORONER		68. SIGNATURE OF JURY		69. SIGNATURE OF COURT	
70. SIGNATURE OF JUDGE		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF CORONER	
73. SIGNATURE OF JURY		74. SIGNATURE OF COURT		75. SIGNATURE OF JUDGE	
76. SIGNATURE OF SHERIFF		77. SIGNATURE OF CORONER		78. SIGNATURE OF JURY	
79. SIGNATURE OF COURT		80. SIGNATURE OF JUDGE		81. SIGNATURE OF SHERIFF	
82. SIGNATURE OF CORONER		83. SIGNATURE OF JURY		84. SIGNATURE OF COURT	
85. SIGNATURE OF JUDGE		86. SIGNATURE OF SHERIFF		87. SIGNATURE OF CORONER	
88. SIGNATURE OF JURY		89. SIGNATURE OF COURT		90. SIGNATURE OF JUDGE	
91. SIGNATURE OF SHERIFF		92. SIGNATURE OF CORONER		93. SIGNATURE OF JURY	
94. SIGNATURE OF COURT		95. SIGNATURE OF JUDGE		96. SIGNATURE OF SHERIFF	
97. SIGNATURE OF CORONER		98. SIGNATURE OF JURY		99. SIGNATURE OF COURT	
100. SIGNATURE OF JUDGE		101. SIGNATURE OF SHERIFF		102. SIGNATURE OF CORONER	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7712

## CERTIFICATE OF DEATH

07703

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, #26</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House In The Pines Nursing Home</b>				d. STREET ADDRESS <b>#6408 Arundel Cove Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>MIMA A. STEGMAN</b>				4. DATE OF DEATH <b>July 21 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>7th July 1881</b>		9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Solley</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Audry Dashiell</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Carcinoma of Stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>1 1/2 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-22-1961</b> to <b>7-22-1961</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>7-21-1961</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wilmer K. Gallagher</b>				ATTENDING MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>				22d. ADDRESS <b>6209 Frederick Ave., Baltimore 28, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>25th July 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brooklyn RFD, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Smith</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 26 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

03703

7333

(M)

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Baltimore: Maryland

Catonsville, 652

House in the Pinehurst

MINN. A. STEPHAN July 21

72 July 1981

Housework (rel.) Can Home Wood Branch Co., Md., U.S.A.

Thomas Solis

no name Mrs. Betty Washell - 2nd fl

*Handwritten notes:*  
Baltimore, Maryland  
Baltimore, Maryland

*Handwritten notes:*  
Baltimore, Maryland  
Baltimore, Maryland  
Baltimore, Maryland  
Baltimore, Maryland

Baltimore, Maryland

Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7713

## CERTIFICATE OF DEATH

07704

1. NAME OF DECEASED  
(Type or Print)

Mary S. Stewart

2. DATE OF DEATH

7/11/61

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Augsburgh Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Balto. 15, KIXESVILLE Md.

D. STREET ADDRESS

(If rural, give location)

Augsburgh Home 3211 Dorchester Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)

If Under 1 Year

If Under 24 Hours

Months

Days

Hours

Min.

10. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Geo. Schley

14. MOTHER'S MAIDEN NAME

Lydia Burkert

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Mr. S.R.Schley (Bro)

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Senile Psychosis

6 months

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from July 11 - 1961 that (I) (we) last saw the deceased alive on July 10 - 1961 and that in (my) (our) opinion death occurred at 10 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Earl L. Chambers

M. D.

23B. ADDRESS

4108 Liberty Hts G. Balto. Md.

23C. DATE SIGNED

7/12/61

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

7/14/61

24C. NAME OF CEMETERY OR CREMATORY

Lorriane Park Cem

24D. LOCATION

(City, town, or county)

City

ADDRESS

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

WIEDEFELD &amp; SON

10707

817

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

REPORT OF INVESTIGATION

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

DATE: 10/10/68

TIME: 10:00 AM

REPORT MADE AT: NEW YORK

REPORT MADE BY: [REDACTED]

CHARACTER OF CASE: [REDACTED]

SYNOPSIS: [REDACTED]

DETAILS: [REDACTED]

CONCLUSION: [REDACTED]

RECOMMENDATION: [REDACTED]

ADMINISTRATIVE: [REDACTED]

APPROVED: [REDACTED]

SPECIAL AGENT IN CHARGE

TO REPLY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7714 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G290 7/14/61 iwk

Reg. Dist. No. 07705

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN lb <b>25yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		d. STREET ADDRESS <b>65 Keyser Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>65 Keyser Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>H.</b> Middle <b>Frank</b> Last <b>Storm</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1882 1879</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b>	
11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Storm</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ralph W. Storm, 1422 W. Joppa Rd. Baltimore 4, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>none</b> DUE TO (c) <b>none</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>7-6-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carrolls Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>July 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>			

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]  
 SEX: [REDACTED] AGE: [REDACTED]  
 RACE: [REDACTED] BIRTH DATE: [REDACTED]  
 PLACE OF BIRTH: [REDACTED]  
 OCCUPATION: [REDACTED]  
 MARITAL STATUS: [REDACTED]  
 DATE OF DEATH: [REDACTED]  
 TIME OF DEATH: [REDACTED]  
 PLACE OF DEATH: [REDACTED]  
 CAUSE OF DEATH: [REDACTED]  
 MANNER OF DEATH: [REDACTED]  
 SIGNATURE OF EXAMINER: [REDACTED]  
 OFFICIAL SEAL: [REDACTED]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7715  
07706

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u> c. LENGTH OF STAY IN lb <u>45 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Poplar Hill Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u> d. STREET ADDRESS <u>1 Poplar Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Stroh</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 January 1874</u>	9. AGE (In years, last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Stroh</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Knopp</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Daughter - Ida Temple</u> Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Heart failure</u> <u>422.1</u> DUE TO <u>Arterio-sclerotic Cardio-Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>over 6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>over 6 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956 July 19</u> to <u>July 1961</u> , that (I) (we) last saw the deceased alive on <u>29 July 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter T. Kees</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>				22d. ADDRESS <u>Cockeysville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8.1.61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>POPULAR GROVE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WARREN</u> <u>MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Barnes Brown</u> ADDRESS <u>Towson</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7716

07707

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Alleghany</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>36yr11mthldy</b>		d. STREET ADDRESS <b>Spring Gap</b>	
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gilbert</b> Middle <b>E.</b> Last <b>Taschenberger</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Taschenberger</b>		14. MOTHER'S MAIDEN NAME <b>Frances Little</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>None unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>491x</b> (c) <b>491x</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>Aug. 23, 1924</b> to <b>July 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>July 24, 1961</b> , and that death occurred at <b>2:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Aristides Simopoulos, M. D.</b>		22b. DATE SIGNED <b>7-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aristides Simopoulos, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>7-27-61</b>	23b. DATE THEREOF <b>7-27-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>mt. zabor methodist Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. W. Murphy</b>		25a. REC'D BY REGISTRAR <b>JUL 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

10701

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Cherry Point

10716 Cherry Point

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7717

07703

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 7</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3612 SYLVAN DRIVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CYRIL</b> Middle <b>ROBINSON</b> Last <b>TAYLOR</b>				4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 9, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ENGINEER</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>ROBINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>4</b>		17. INFORMANT <b>WIFE</b> Address <b>MRS. PATRICIA TAYLOR - 3612 SYLVAN DRIVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL HEMORRHAGE</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE 10 YEARS.</b> DUE TO <b>CORONARY INSUFFICIENCY</b> (c) <b>5 YEARS.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 10, 1961</b> to <b>JULY 7, 1961</b> that (I) (we) last saw the deceased alive on <b>7/6</b> 19 <b>61</b> and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edwin L. Pierpont</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>				22d. ADDRESS <b>8204 LIBERTY RD. - BALTO. 7, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>JULY 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chomowetz Jr.</b> ADDRESS <b>3617 Chestnut Ave.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William A. Korman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7718

CERTIFICATE OF DEATH

Reg. Dist. No. 07709

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE IN PINES</b>		d. STREET ADDRESS <b>1102 S. SYMINGTON AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>KATE</b> Middle <b>TAYLOR</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31st</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 24, 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASST. BUYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>AUGUSTUS TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>MARIA TATUM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SECURITY NO.	
17. INFORMANT <b>Mrs. Harvey Markuser</b>		Address <b>102 S. Symington Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Hypertensive Cardio-Vascular-Renal Disease</b> DUE TO (c) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-16-1960</b> to <b>7-31-1961</b> , that I last saw the deceased alive on <b>7-31-1961</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		ADDRESS (Street, city or town, state) <b>6309 Frederick Ave.</b> DATE SIGNED <b>7/31/61</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		<b>Baltimore-28, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>8-3-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Julius Cunningham</b>		ADDRESS <b>F.H. Catonville, Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Phana</b>	

(M)

(I)

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7719 CERTIFICATE OF DEATH 07710

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Route 1</b>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR L. TENNEY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/10/18</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commerical</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Elkins, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Tenney</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Townsend</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>218-07-4975</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>ASTROCYTOMA</b> 1973-9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>URINARY TRACT INFECTION</b> (c) <b>2 MONTHS</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>April 29</b> ....., 19 <b>61</b> to <b>July 8</b> ....., 19 <b>61</b> that <b>1/1</b> (we) last saw the deceased alive on <b>July 8</b> ....., 19 <b>61</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski</b>		22b. DATE SIGNED <b>7/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 11, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Gardens</b>	23d. LOCATION (City, town or county) (State) <b>Finksburg, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elines Funeral Home,</b>		25a. REC'D BY REGISTRAR <b>Reisterstown, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>		DATE <b>JUL 11 '61</b>	

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7720

## CERTIFICATE OF DEATH

Reg. Dist. No. 07711

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. LENGTH OF STAY IN 1b <b>3 wks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium Towson 4, Maryland</b>		d. STREET ADDRESS <b>124 Bridge Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>McCormick</b> Last <b>Terrell</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/96</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>nursing profes.</b>	
11. BIRTHPLACE (State or foreign country) <b>Del Rapid, S.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Harrie Graham McCormick</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise Breitinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-32-1143</b>	
17. INFORMANT <b>Personal History &amp; Hospital Records, Eudowood Sanatorium</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b> <b>465 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X Pulmonary Tuberculosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>14X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/12</b> , 19 <b>60</b> , to <b>7/17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>7/17</b> , 19 <b>61</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Milton B. Kress</b>		DATE SIGNED <b>7/17/61</b>	
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M. D.</b>		<b>Eudowood Sanatorium, Towson 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/21/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BETHEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>NR. CHESAPEAKE CITY, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Piffin Funeral Home 91.92, Elkton Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 24 '61</b>	
ADDRESS <b>578 main st</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. SMITH

2. Sex: Male

3. Age: 45

4. Date of Birth: 1910-03-15

5. Date of Death: 1955-08-20

6. Place of Birth: Baltimore, Maryland

7. Usual Residence: 1234 Main St., Baltimore, Md.

8. Cause of Death: Myocardial Infarction

9. Duration of Illness: 2 weeks

10. Place of Death: Home

11. Attending Physician: Dr. J. H. Jones

12. Burial Place: Greenwood Cemetery, Baltimore, Md.

13. Signature of Physician: [Signature]

14. Signature of Registrar: [Signature]

15. Date of Registration: 1955-08-25

RECEIVED  
BALTIMORE  
AUG 25 1955  
STATE DEPARTMENT OF HEALTH

TO HOUSING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
07712														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ft Howard</b>					c. LENGTH OF STAY in 1b <b>84 Days</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Saint Michaels</b>									
d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>JOHN L. THOMAS</b>					4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 24, 1891</b>		9. AGE (In years last birthday) <b>70</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Talbot County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>Robert Thomas</b>					14. MOTHER'S MAIDEN NAME <b>Annie Fields</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW-1</b>					16. SOCIAL SECURITY NO. <b>WW-1</b>					17. INFORMANT Address <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>LEFT LOWER LOBE PNEUMONIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
2Dc. TIME OF INJURY Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)								
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 28, 1961</b> , to <b>July 21, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 21, 1961</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Frederick S. Donaldson</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>7-22-61</b>									
22c. PHYSICIAN'S NAME (Type or print)					22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>St Michaels Maryland</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>					25a. REC'D BY REGISTRAR <b>1000 Brantley Ave. Baltimore 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							
25c. DATE <b>JUL 25 '61</b>														

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07713

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8627 Hoerner Avenue</b>		d. STREET ADDRESS <b>8627 Hoerner Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>STEVEN</b> Middle <b>LEE</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1961</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>3</b> Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert B. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Joan W. Windsor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>Albert B. Thomas</b>	
17. INFORMANT <b>same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pneumonitis</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter W. Rieckert</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Peter W. Rieckert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Associate Pathologist <b>x</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-26-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Rd.</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Conroy J. P. [Signature]</b>		DATE <b>7/24/61</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07714									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>207 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>17</b> d. STREET ADDRESS <b>1720 Riggs Avenue</b>				
3. NAME OF DECEASED (Type or print) <b>WALTER</b> First Middle Last <b>THOMAS</b>					4. DATE OF DEATH Month Day Year <b>July 5 1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 26, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government Camp</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Lucy Thomas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clinical Recored, VAH, Baltimore 18, Maryland</b>		18. ADDRESS <b>Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BURNS 1ST, 2ND AND 3RD DEGREE ANTERIOR SURFACE OF</b> <b>916.7 XXXX BODY AND FACE.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>PULMONARY CONGESTION AND EDEMA</b> <b>XXXX</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>CLOTHING CAUGHT FIRE WHILE HE WAS SITTING ON COMMODE.</b>									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. <b>10:25 xxx</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA HOSPITAL</b>		20f. (City or town) <b>FORT HOWARD, BALTO., MARYLAND</b>		20g. (County) <b>BALTO.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>M B Davis</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <b>7/5/61</b>				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or country) <b>Baltimore 28, Maryland</b>		22e. (State)	
23. FUNERAL DIRECTOR <b>Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.</b>					24a. REC'D BY REGISTRAR <b>JUL 10 61</b>				
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>									

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WILLIAM H. HAYES, D.D.

Miss O. Wilson, 1000 Broadway Ave., Boston, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b> c. LENGTH OF STAY IN 1b <b>FOYLEIGH CONVALESCENT HOME</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE MD.</b> d. STREET ADDRESS <b>BLACKSTONE APTS.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA G.</b> Middle <b>TOWNSEND</b> Last 4. DATE OF DEATH Month <b>7</b> Day <b>19</b> Year <b>1961</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>AUG. 4, 1865</b> 9. AGE (In years last birthday) <b>95</b> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b> 11. BIRTHPLACE (County & State, or foreign country) <b>CONN.</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>ELLSWORTH GOODYEAR</b> 14. MOTHER'S MAIDEN NAME <b>SARAH BISHOP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>—</b> 17. INFORMANT <b>D. Michener L.P.N.</b> Address <b>Sykesville MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis right femoral artery</b> 450.0 DUE TO <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3 July, 1961</b> to <b>19 July, 1961</b> , that (I) (we) last saw the deceased alive on <b>18 July, 1961</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Paul L H Rouse MD</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>19 July 61</b> 22c. PHYSICIAN'S NAME (Type) <b>Paul L H Rouse MD</b> 22d. ADDRESS <b>1903 Foley La. Pikesville MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>7-22-61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>GROVE STREET</b> 23d. LOCATION (City, town or county) (State) <b>NEW HAVEN, CONN.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN D. MITCHELL &amp; SONS, INC. 1900 FULTON PL.</b> ADDRESS 25a. REC'D BY REGISTRAR <b>JUL 24 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	

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STATE OF NEW YORK

1894

First of January, 1894  
Home Conn.  
Governor  
Bishop

State of New York  
Grover Street  
Newman Conn.  
1894



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

7723 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07717

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Nursing Home 16 Rusting Avenue (Home)</b>		d. STREET ADDRESS <b>1523 Park Grove Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Violet</b> Middle <b>May</b> Last <b>Turner</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug, 8, 1886</b>
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur C. Ward</b>		14. MOTHER'S MAIDEN NAME <b>Pollie W. Banks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>011-05-9513D</b>	
17. INFORMANT <b>Gordon J. Turner, 1523 Park Grove Ave. Zone 28</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral-vascular accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>April 6, 1961</b> to <b>7/19/61</b> , that (I) (we) last saw the deceased alive on <b>7/19/61</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Christian S. Mass, M.D.</b>		22b. DATE SIGNED <b>7/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Christian S. Mass, M.D.</b>		22d. ADDRESS <b>Baltimore Natl. Pike and St. Johns Lane, Ellicott City, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>7-21-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Medford, Mass</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>JUL 24 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07715

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>25 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 1719 Pinewood Drive</b>				d. STREET ADDRESS <b>1719 Pinewood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William S Titus</b>				4. DATE OF DEATH Month Day Year <b>July 20, 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 29, 1908</b>		9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glenn L. Martin Co.--&amp; sold Bibles</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse L. Titus</b>				14. MOTHER'S MAIDEN NAME <b>Pleasie Mc Peck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-18-6185</b>		17. INFORMANT Address <b>Mrs. Lena Titus 1719 Pinewood Dr. 22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of Kidney, right</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Jack Collins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack Collins, MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-24-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>				ADDRESS <b>7922 Wise Ave., 22, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 24 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7727 CERTIFICATE OF DEATH 07718

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Anne Arundel County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - <del>Baltimore</del> Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5102 Benson Ave.</b>		d. STREET ADDRESS <b>1131 Armistead</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Mary</b> Last <b>Vaeth</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1904</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ferdinand Truffer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Burns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. John J. Vaeth, Sr. (same)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach with widespread abdominal metastases</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>10 mos.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <b>4/1/61</b> 19 to <b>7/11/61</b> 19, that (I) (we) last saw the deceased alive on <b>7/8/61</b> 19, and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>C. Arthur Rossberg, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>7/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Arthur Rossberg, M.D.</b>		22d. ADDRESS <b>2436 Washington Blvd., Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-15-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gence - 4001 Ritchie Hwy. - Baltimore</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

STATE OF TEXAS  
COUNTY OF DALLAS

1921

(M)

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7728

CERTIFICATE OF DEATH

07719

1. PLACE OF DEATH a. COUNTY <b>County- Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>408 Reisterstown Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>408 Reisterstown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John W. Veise</b>				4. DATE OF DEATH <b>July 7, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 8, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer- Retired self</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>? Veise</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-01-5755</b>			
17. INFORMANT <b>Rev. Nelson F. Veise</b>				Address <b>1801 Thornbury Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b> DUE TO (b) <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>few years</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1953</b> to <b>July 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>June 21, 1961</b> and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <b>Paul H Royse</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Paul H Royse</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>1403 Foley Lane Pikesville Md.</b> 22b. DATE SIGNED <b>7 July 61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. McKelvey &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>North + B. Ave., Baltimore Md.</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony S. Kline</b>			

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1940-1941

1942-1943

1944-1945

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1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

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1962-1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7725  
7725  
CERTIFICATE OF DEATH

Reg. Dist. No. 07721

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. LENGTH OF STAY IN lb <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>		d. STREET ADDRESS <u>37 Ebenezer Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S</u> Last <u>Vincent</u>		4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Ca.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>	IF UNDER 24 HRS. Min. <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>	11. BIRTHPLACE (State or foreign country) <u>White Marsh Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard Vincent Jr</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Morrill</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Stephen W Vincent</u> Address <u>Box 602 White Marsh</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>61</u> , to <u>7/2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7/2</u> , 19 <u>61</u> , and that death occurred at <u>5 A</u> .M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard Burger</u> M.D. <u>Ridge Rd</u>		ADDRESS (Street, city or town, state) <u>Baltimore 6, Md</u>	
PHYSICIAN'S NAME (Type) <u>Fuller Medical Group</u>		DATE SIGNED <u>Jul 6 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-5-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chase Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Jul 6 '61</u>	
ADDRESS <u>7401 Belair Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7730

## CERTIFICATE OF DEATH

Reg. Dist. No.

07720

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baldwin Mill Road</u>		d. STREET ADDRESS <u>1 Baldwin Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph Edward Vining</u> First Middle Last		4. DATE OF DEATH <u>July 11 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 29, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Metaburgical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Massachusetts</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seth Vining</u>		14. MOTHER'S MAIDEN NAME <u>Eizette ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-0147</u>	
17. INFORMANT <u>Mrs. Eleanor Mary Vining,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer prostate &amp; metastasis</u> 177X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 _____ p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 10, 1961</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>7-11-61</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Jul 13 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	





7731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07722

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>206 E. Susquehanna Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>206 E. Susquehanna Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROWLAND W. WALLIS</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>7 27 19 61</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-7-27</b>	
<b>9. AGE</b> (In years last birthday) <b>33</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Auto mechanic</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Repair shop owner</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Rowland O. Wallis</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Esther E. Pyle</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-26-4955</b>		<b>17. INFORMANT</b> <b>Family records</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>Confluent bronchial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> <b>Part</b> NO <input type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>William V. Lovitt, Jr.</i>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <b>William V. Lovitt, Jr., M.D.</b>				<b>DATE SIGNED</b> <b>7-28-61</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>7/31/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dulaney Valley Mem. Gardens</b>		<b>22d. LOCATION</b> (City, town, or country) (State) <b>Timonium Md.</b>	
<b>23. FUNERAL DIRECTOR</b> <i>John Burns Sons</i> <b>Towson</b>				<b>24a. REC'D BY REGISTRAR</b> <b>AWG 4 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>William S. Hanna</i>	

(M)

(1)

Rowland O. Wallis

Barthel A. Lyle

51A-36-4955

family records

none

USA

Repair shop owner Maryland

Timonium Md.

Delaney, Walter H. Carbons

7/21/61

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

7732

07723

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>1yr3mth13days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3201-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>501 W. University Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>James</u> Last <u>Watt</u>				<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>23</u> Year <u>1961</u>											
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 30, 1877</u>		<b>9. AGE (In years last birthday)</b> <u>84</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>salesman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Scotland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>William Watt</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Berbinia Watt</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>				<b>16. SOCIAL SECURITY NO.</b> <u>092-09-7984</u>		<b>17. INFORMANT</b> <u>Records: SPRING GROVE STATE HOSPITAL</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease, in failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>											
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 14, 1961</u> <b>to</b> <u>July 23, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>July 23 (AM) 1961</u> , <b>and that death occurred at</b> <u>AM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Imre Kopits, M.D.</u>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>11:25</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Imre KOPITS, M.D. (K-7077).</u>				<b>22d. ADDRESS</b> <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>7-26-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. OLIVET</u>				<b>23d. LOCATION (City, town or county)</b> <u>BALTO.</u>				<b>(State)</b> <u>MO</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.W. JENKINS &amp; Sons Co. 4905 YORK RO.</u>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 25 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Thomas</u>					

MEDICAL CERTIFICATION

(M)

(I)

H.W. JENKINS / 2nd Co. 41st York Regt  
Rochester N.Y. 14601  
JAN 25 1961

PAID

MO

7733

## CERTIFICATE OF DEATH

Reg. Dist. No. 07724

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cub Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cub Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2811 North Wind Rd</u>		d. STREET ADDRESS <u>1 2811 North Wind Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis C WeichselDorfer</u>		4. DATE OF DEATH Month Day Year <u>July 10 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-16-1902</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vending Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John WeichselDorfer</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA Schrank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-01-7699</u>	
INFORMANT Address <u>Edith WeichselDorfer</u>		<u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/10/61</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>7/10/61</u> , 19____, and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Grott</u>		ADDRESS (Street, city or town, state) <u>8100 Hartford Rd</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Grott, M.D.</u>		DATE SIGNED <u>7/10/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 13-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO-14, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS &amp; Son</u>		ADDRESS <u>8802 Hartford Rd</u>	
24a. REC'D BY REGISTRAR <u>JUL 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

(M)

(1)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07725

1. NAME OF DECEASED  
(Type or Print)

Marie Weidenhammer

2. DATE OF DEATH

July 13, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

Baltimore County  
Pikesville

7004 Concord Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Pikesville

D. STREET ADDRESS

(If rural, give location)

7004 Concord Road

5. SEX

female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10-10-1884

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

Retired School teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward W. Weidenhammer

14. MOTHER'S MAIDEN NAME

Mary Nicholas

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

no

16. SOCIAL  
SECURITY NO.

No

17. INFORMANT

ADDRESS

Mrs. Elizabeth Bain- 7004 Concord Road

18.

### CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

443X (A) Hypertensive ASCVD  
DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

3 1/2 yrs

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

### II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

22. I certify that (I) (this hospital) attended the deceased from 6/9/58 to 7/13/61  
and that in (my) (our) opinion death occurred at 5:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE

Francis W. Gluck

23b. ADDRESS

100 W University Pkwy

23c. DATE SIGNED

7/14/61

24a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24b. DATE

7-17-61

24c. NAME OF CEMETERY OR CREMATORY

Loudon Park

24d. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25a. DATE REC'D BY HEALTH DEPT.

III 15 1961

25b. NAME OF REGISTRAR

William S. Williams

25c. FUNERAL DIRECTOR

Wm. J. Tucker-Sons Balto., Md.

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

15770

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315MEMORANDUM FOR THE CHIEF OF STAFF  
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

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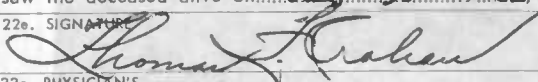

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**7735**

**07726**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>32 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>-</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2129 Parksley Avenue</b>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE Frank WEIH Jr</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>30</b> Year <b>19 61</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 26, 1921</b>		<b>9. AGE (In years last birthday)</b> <b>40</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>40</b> Days <b>40</b> Hours <b>40</b> Min. <b>40</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life even if retired) <b>Power Transmission Station Operator</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gas &amp; Electric Co.</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>George F. Weih, Sr.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen M. Sickler</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW-11</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-14-6469</b>				<b>17. INFORMANT</b> <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC EMBRYONAL CARCINOMA OF TESTES</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 DAYS</b> <b>8 MONTHS</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>e.m.</b> p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 28</b> , 19 <b>61</b> to <b>July 30</b> , 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 30</b> , 19 <b>61</b> , and that death occurred at <b>9:00</b> P.M. from the causes and on the date stated above.											
<b>22a. SIGNATURE</b>  M.D.						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>7-31-61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>						<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8-3-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook, Inc.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>AUG 1 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08938

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MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/28/61	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	22d. LOCATION (City, town, or county) Baltimore Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter-3035 W. North Ave.		ADDRESS	24a. REC'D BY REGISTRAR DATE AUG 10 '61	24b. REGISTRAR'S SIGNATURE William S. Thomas

8038

CERTIFICATE OF DEATH

DATE

FILE NO.

AGE

SEX

RACE

EDUCATION

RELIGION

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF INTERMENT

DATE OF INTERMENT

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF CREMATION

DATE OF CREMATION

PLACE OF EXHUMATION

DATE OF EXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REBURIAL

DATE OF REBURIAL

PLACE OF RECREMATION

DATE OF RECREMATION

PLACE OF REEXHUMATION

DATE OF REEXHUMATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07727**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8016 EASTERN BLVD. #24.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> <span style="float: right;">b. COUNTY <b>BALTIMORE</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b> d. STREET ADDRESS <b>8016 EASTERN BLVD.</b> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></span>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>DAVID Robert Wheatley</b> First Middle Last				<b>4. DATE OF DEATH</b> Month <b>7</b> Day <b>30</b> Year <b>1961</b>											
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>NOV. 17, 1883.</b>		<b>9. AGE</b> (In years last birthday) <b>77 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>GROCEER</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>HARFORD Co., MD.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>WESLEY WHEATLEY</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY ?</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>CLARA S. WHEATLEY</b> <span style="float: right;">Address <b>SAME.</b></span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> <b>DUE TO</b> <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b>												INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a. m. p. m.		Month, Day, Year <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b>		(County)		(State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <i>Jack C Collins</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <b>7-30-61</b>			
<b>EXAMINER'S NAME (Type)</b> <b>JACK C COLLINS</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>8-2-61.</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>OAK LAWN CEM.</b>				<b>22d. LOCATION</b> (City, town, or county) <b>7225 EASTERN BLVD. MD.</b> (State)					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Charles S. Zales</i>						ADDRESS <b>6224 EASTERN AVE. BALTO., 24, MD</b>				<b>24a. REC'D BY REGISTRAR</b> <b>AUG 2 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF MEDICAL EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF REGISTRAR [REDACTED]	
13. SIGNATURE OF CLERK [REDACTED]		14. SIGNATURE OF JURY [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
39. SIGNATURE OF JURY [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]	
45. SIGNATURE OF JURY [REDACTED]		46. SIGNATURE OF JURY [REDACTED]	
47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
51. SIGNATURE OF JURY [REDACTED]		52. SIGNATURE OF JURY [REDACTED]	
53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]	
57. SIGNATURE OF JURY [REDACTED]		58. SIGNATURE OF JURY [REDACTED]	
59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
63. SIGNATURE OF JURY [REDACTED]		64. SIGNATURE OF JURY [REDACTED]	
65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
69. SIGNATURE OF JURY [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]	
75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]	
87. SIGNATURE OF JURY [REDACTED]		88. SIGNATURE OF JURY [REDACTED]	
89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]	
93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7737

CERTIFICATE OF DEATH

07728

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>39 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1707 Barnes Street</b> d. STREET ADDRESS <b>3601-A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PERLEY</b> <b>WILLIAMS</b>		4. DATE OF DEATH <b>July 16 19 61</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1923</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G. S. A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Halifax, N. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Matthew Williams</b>		14. MOTHER'S MAIDEN NAME <b>Katie Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>240-26-4292</b>		17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> 445 X DUE TO <b>ARTERIOIAR NEPHROSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>MALIGNANT HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 7 1961</b> to <b>July 16 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>July 16 1961</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD., FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>	
23d. LOCATION (City, town or county) <b>Baltimore</b>		23e. (State) <b>Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 19 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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Dr. M. J. C. Green, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7739 CERTIFICATE OF DEATH 07730

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b> c. LENGTH OF STAY IN 1b <b>20 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MASONIC HOME</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>-</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3516 GARRISON AVE</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA LEE WILSON</b>			4. DATE OF DEATH Month Day Year <b>JULY 3 1961</b>		
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-1867</b>	9. AGE (In years last birthday) <b>94</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAID</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>JOHN WILSON</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>Frank R. Smith Jr. - Cockeysville Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-22-11</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>10 years.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> , 19 <b>61</b> , to <b>7-3</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7-2</b> , 19 <b>61</b> , and that death occurred at <b>1961</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Walter T. Kees</b> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>7/3/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>			22d. ADDRESS <b>COCKEYSVILLE, MD</b>		
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>7-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>			ADDRESS		
25a. REC'D BY REGISTRAR <b>JUL 5 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Charles S. Kenna</b>		

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W. Cook, Inc., 1217 St. Paul Street

BURBANK 7-8-51 London Park Property

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7738

CERTIFICATE OF DEATH

07729

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Fallston, Md.</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston, Harford Co., Maryland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>Connley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Ellwood</b> Last <b>WINSKOWSKI</b>				4. DATE OF DEATH Month <b>7</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/18/32</b>	
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.		IF UNDER 24 HRS. Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- - -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>- - -</b>							
13. FATHER'S NAME <b>Edward Herman Winskowski</b>				14. MOTHER'S MAIDEN NAME <b>Gladys Elizabeth Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>Parents and Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of vomitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>dehydration; electrolyte imbalance</b> DUE TO (c) <b>- - -</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>3 days.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Microcephalic with spastic quadriplegia (Birth)</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>7/23/61</b> to <b>7/23/61</b> , that (I) (we) last saw the deceased alive on <b>7/23/61</b> at <b>3:15 p.m.</b> , and that death occurred at <b>3:15 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Harry B. Butler</b>				22b. DATE <b>7/23/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Harry B. Butler</b>	
22d. ADDRESS <b>M.D.</b>				22e. ADDRESS <b>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL Air Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>BEL Air, Harford Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O Mitchell</b>				25a. REC'D BY REGISTRAR <b>7/24/61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>	

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TO HOPEFUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7740  
CERTIFICATE OF DEATH

07731

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>811 MORRIS AVE</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b> d. STREET ADDRESS <b>811 MORRIS AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILLIAM H. WOOD SR.</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>July 25 1961</b>					
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JULY 16, 1890</b>	<b>9. AGE</b> (In years last birthday) <b>71</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED ELECTRICIAN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>THEATRICAL</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>NEW YORK</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>WILLIAM H. WOOD</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH MORTON</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>MR. MORTON WOOD 811 MORRIS AVE LUTHERVILLE</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>157X</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 7 mos</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>2Db. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>2Dc. TIME OF INJURY</b> Hour a.m. p.m. <b>19</b>	<b>2Dd. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from July 1, 1956 to July 24, 1961, that (IV) (we) last saw the deceased alive on July 24, 1961, and that death occurred at 6:11 AM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>George T. Gilmore</b> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>GEORGE T. GILMORE, MD</b>		<b>22d. ADDRESS</b> <b>Lutherville, md</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>23b. DATE THEREOF</b> <b>JULY 27, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>LOUDON PARK CEMETERY</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>BALTIMORE, MARYLAND</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HENRY W. JENKINS &amp; SONS</b>		<b>ADDRESS</b> <b>4905 YORK RD BALT 12</b>		<b>25a. REC'D BY REGISTRAR</b> <b>AUG 26 '61</b>			
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Fennell</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07732

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2511 Ambler Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>RADCLIFF</b> Last <b>WOODMANCY</b>				4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 12, 1921</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Ohiopyle, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Woodmancy</b>				14. MOTHER'S MAIDEN NAME <b>Ella Corristan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>173-18-7287</b>		17. INFORMANT <b>Munk Funeral Home, Connellsville, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head.</b> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head.</b>			
20c. TIME OF INJURY Hour <b>1:15</b> a.m. <b>7/4</b> 19 <b>61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Dundalk Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7/4/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Johnson Chapel Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Henry Clay Township, Pa.</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook Inc., 1217 St. Paul St. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 6 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

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7742 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 3, Film G-290 7/12/61 c.c.

07733

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>XXXXX Delaware</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>		d. STREET ADDRESS <b>105 Washington St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>C. E.</b> Last <b>Wuntz</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1885</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>piano tuner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Herman Wuntz</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Hensler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>221 22 2231</b>	
17. INFORMANT <b>Charles Wuntz</b>		Address <b>363 Oaklee Village #29</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO <b>Decubitus Ulcers Multiple</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hemiplegia left old</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Hip left with Pinning 1957</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/3/61</b> to <b>7/9/61</b> that (I) <b>was</b> last saw the deceased alive on <b>7/7/61</b> and that death occurred <b>6:20 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. E. McGrath</b>		22b. DATE SIGNED <b>7/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. E. McGrath, M.D.</b>		22d. ADDRESS <b>1303 Frederick Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/12/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 11 '61</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

48X-3

28/10/61

CERTIFICATE OF DEATH

(M)

(I)

Section 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, by the funeral director, after this certificate has been signed by the attending physician and completely filled. Pages 3 and 4 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7743

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07734

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mth17dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Watson</b> Middle <b>Edward</b> Last <b>Yox, Sr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>705-05-5966</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO <b>Arterioscl. general. severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 28, 1959</b> to <b>7/3, 1961</b> , that (I) (we) last saw the deceased alive on <b>7/3, 1961</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 26, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>July 7, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION (City, town, or county) (State) <b>WOODLAWN Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. L. Schmitt</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Kenna</b>			

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7744 CERTIFICATE OF DEATH 07735

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>3yr5mth22dys</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>30 S. Carrollton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret Ann Zentgraf</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1866</b>
9. AGE (In years last birthday) <b>95</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Kaiser</b>		14. MOTHER'S MAIDEN NAME <b>Louisa KEEBLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 20, 1958</b> , to <b>July 28, 1961</b> that (I) (we) last saw the deceased alive on <b>July 28, 1961</b> , and that death occurred at <b>1:35</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Aristides Simopoulos, M. D.</b>		22b. DATE SIGNED <b>7-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aristides Simopoulos, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL Aug. 1, 1961</b>		23b. DATE THEREOF <b>Aug. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NEW Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis W. Miller</b>		25a. REC'D BY REGISTRAR <b>AUG 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. ADDRESS <b>2101 Rudwick Ave.</b>	

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